Health Care Case Law in India

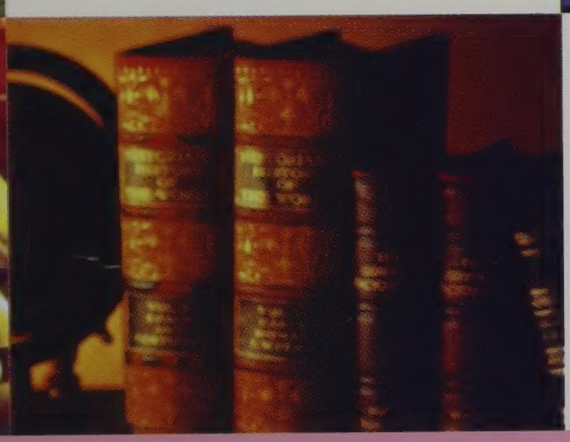


Public Health Care









Right to Health



A Reader

Editors

Adv. Mihir Desai
Adv. Kamayani Bali Mahabal

Cehat
Centre for Enquiry into Health and Allied Themes

ICHRL
India Centre for Human Rights & Law

Health Care Case Law in India

A Reader

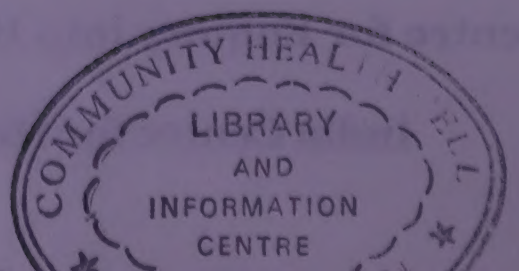
Editors

Adv. Mihir Desai
Adv. Kamayani Bali Mahabal

612
8/10/07

Centre for Enquiry into Health and Allied Themes (CEHAT)
And
India Centre for Human Rights & Law (ICHRL)

RHR-130
10093



Contents

Foreword v

Preface vii

CHAPTERS:

1 **Right to Health and Health Care- Theoretical Perspective** 1
Ravi Duggal

2 **Fundamental Right to Health and Public Health Care** 17
Adv. Mihir Desai and Adv. Dipti Chand

3 **Right to Emergency Health Care** 37
Adv. Mihir Desai and Adv. Dipti Chand

4 **HIV / AIDS and Law** 47
Adv. Vijay Hiremath

5 **Issues in Medical Practice Care** 61
Adv. Mihir Desai and Adv. Dipti Chand

6 **Medical Negligence** 71
Adv. Mihir Desai and Adv. Dipti Chand

7 **Drugs and Public Health** 87
Adv. Mihir Desai and Adv. Dipti Chand

8 **Right of Workers to Occupational Health and Safety** 103
Adv. Mihir Desai and Adv. Dipti Chand

9 **Environment and Health** 113
Adv. Vijay Hiremath

10 **Mental Health Care** 117
Adv. Mihir Desai and Adv. Kamayani Bali Mahabal

11 **Reproductive Rights** 127
Adv. Vijay Hiremath and Adv. Kamayani Bali Mahabal

12 **National Human Rights Commission** 139
Adv. Kamayani Bali Mahabal

13 **Other Cases** 155
Adv. Mihir Desai and Adv. Kamayani Bali Mahabal

14 **Trends in Judicial Outcomes and Consequences for Health Care** 163
Adv. Mihir Desai

15 **Towards Establishing the Right to Health and Healthcare** 169
Ravi Duggal

Annexure 1 **Cited Cases** 177
Annexure 2 **Legal Glossary** 183
Annexure 3 **Health Legislations** 189
Annexure 4 **Important Court Websites** 197
Annexure 5 **Public Interest Litigation** 199

CONTENTS

Foreword v

Preface vii

CHAPTERS:

1 Rights to Health and Health Care: Theoretical Perspectives 1

2 Rights to Health and Health Care: International Perspectives 15

3 Rights to Health Care and Health Care Reform 31

4 HIV / AIDS and Law 43

5 Environment and Health 53

6 Medical Negligence 67

7 Issues in Medical Research 81

8 Rights of Women to Reproductive Health and Rights 101

9 Drugs and Public Health 113

10 Mental Health Care 125

11 Environmental Rights 135

12 National Human Rights Commission 151

13 Other Cases 159

14 Towards an Ethical Guidance and Conscientiousness for Health Care 169

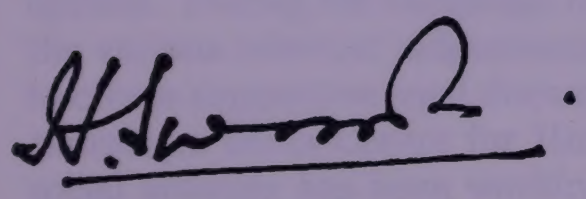
15 Towards Establishing the Right to Health and Healthcare 179

Foreword

The Right to Health and Health care is a human right. It is true that we have included right to health and health care under Article 21 of the Indian Constitution, the Right to Life. However, the judiciary has not really been active in giving a direction in implementing this right. Till the advent of Consumer Courts / Forums, there were hardly any cases of medical negligence. Since then some cases have come to the Court. We have yet to develop our own medical jurisprudence in respect of cases on medical negligence and ethics. The questions of ethics go to the Medical Council but, I think, there is no transparency in their dealings with cases of medical negligence and ethics. The Courts on the other hand, are proverbially slow.

Today in the era of globalization where public services are slowly being privately operated and open to market forces, access to them becomes a correlate of income distribution in which the poorer sectors have to fend for themselves in an increasingly unequal society. What we require is a large number of public hospitals with easy access for the poor, and public health care centres in every village rather than huge five star hospitals in every mega city.

CEHAT and ICHRL have done an excellent job in bringing out this Reader and it is a commendable effort. The Reader provides a comprehensive treatment of the issue and deals with them in a lucid and yet exhaustive manner, offering key solutions to various problems. Clarity is the essence and the writers have condensed without sacrificing essential features of individual cases and principles discernible from vast canvas of controversial topics. It is a much needed contribution in the field of health and human rights and will be useful to social organizations, activists, lawyers and judges.



Justice Hosbet Suresh,
Retired, Bombay High Court.

Preface

The majority of the population of the country is excluded from any statutory recognition of right to health. Constitutional recognition can, at the highest, only provide the framework for further statutory inroads. Judicial pronouncements, then, acquire significance. With the advent of public interest litigation, a large number of issues concerning the poor and marginalized are being agitated in courts across the land. It is important to follow the thinking of the courts on these issues. Even though judicial pronouncements may not have the same breadth as statutory laws, they constitute the law as applicable in given situations. Besides, these pronouncements give legitimacy, recognition and social acceptance to various ideas and constructs which can be used for strengthening rights based campaigns around issues.

This Reader mainly looks at the Constitutional recognition and judicial pronouncements. These case law form the foundation of the right to health care and can support any further public interest litigations on various other areas of public health. The attempt has also been to demystify the laws and make the information accessible to common people , so that the judgments can be used as an effective tool for demanding the right to health care. An awareness of these judgments does not mean that they will be implemented easily, but it is certainly important for further action and the evolving of future strategies, legal or otherwise, towards realizing the right to health.

CEHAT has been working towards realisation of right to health and healthcare , through research and advocacy, for more than a decade. India's legal framework is dualist (as against monist).International laws related to rights cannot be transformed and applied in the country unless there is appropriate domestic legislation. In 2000 with the launch of the Jan Swasthya Abhiyan (JSA)/ People's Health Initiative in India, civil society groups sought to prioritise the right to health and healthcare on its agenda. During the campaign for the right to health care, it was realized that in order to effectively use the various relevant judgements to realize the right to health as a fundamental right there was a need to create supportive legal documentation. This would also help to develop clear legal strategies for this campaign. India Centre for Human Rights and Law (ICHRL), together with a group of lawyers and social activists has been working on human rights especially the social, economic, environmental and cultural rights. CEHAT and ICHRL have productively collaborated to come out with this comprehensive Reader on Health Care Case Law in India. This Reader is a research output of CEHAT's project on 'Establishing Health as a Human Right'.

The Reader is an outcome of the systematic and dedicated effort of a number of people. We would like to thank the authors of the individual chapters, Ravi Duggal, Adv. Deepti Chand and Adv. Vijay Hiremath for their contribution .The draft chapters have been painstakingly read by academics, activists and lawyers who were involved in the rigorous peer review. Our sincere gratitude to Justice B D Pandit; Justice Suresh; Adv. Sanober; Adv. Jaya Sagade; the Community Health Cell team from Bangalore, including Premadas, Rakhal, Naveen and Sathyasree; Mr Naidu and Janardhan from Basic Needs, Bangalore, and CEHAT'S Programme Development Committee who gave us their invaluable inputs that we have tried to incorporate. We accept, however, all responsibility for the remaining omissions and errors. We are thankful to Lina Mathias for her inputs in language editing to select chapters. We would like to extend our gratitude to eSocialSciences' Editing Services for content editing. We also

express our sincere gratitude to Rashmi Divekar and Pinky Bhatt who have provided invaluable assistance in the final publishing of the Reader.

Finally, this Reader would not have seen the light of day without the financial resources generously extended to us by OXFAM NOVIB, the Ford Foundation and the Rangoonwalla Foundation.

Adv. Mihir Desai
ICHRL

Adv. Kamayani Bali Mahabal
CEHAT

One

Right to Health and Health Care Theoretical Perspectives

Ravi Duggal

Introduction

The Indian Constitution provides a framework for a welfare/socialist pattern of development. While civil and political rights are enshrined as Fundamental Rights that are justiciable, social and economic rights like health, education, livelihoods etc. are provided for as Directive Principles for the State and hence not justiciable. The latter comes under the domain of planned development, which the State steers through the Five Year Plans and other development policy initiatives.

Post-independence India adopted a development paradigm that aimed at creating limited entitlements to a wide range of resources for the underserved people. While this was critical to India's economic development it also contributed substantially to the growth of private capital. The State also actively participated in the productive sectors of the economy, especially capital goods industry. This often subsidized inputs for private sector growth. In the social sector the approach was not very different.

The development paradigm adopted by the political leadership and the state had a social dimension, but also supported private sector growth. To take two examples, while private pharmaceutical industry got a lot of subsidy and support for its growth, drug price control helped keep the prices on a leash. Similarly, while production of doctors contributed largely to the development of private markets in the health sector, the government evolved a system of limited entitlements for healthcare through a primary healthcare system in rural areas, and district and town hospitals and dispensaries in urban areas. However, the development approach was never rights-based and hence the limited entitlements that were made under different development programmes, including healthcare, had a limited impact. The contribution of the Five Year Plans to the social sectors has been abysmally poor; less than one-fifth of the Plan resources have been invested in this sector. Health, water supply and education are the three main sub-sectors under social services.

Within the State's development strategy the health sector has always been a weak link. For the political class it had little value because at one level the private health sector, at least for non-catastrophic care, was already well entrenched and was reasonably accessible, and at another for the poor masses non-catastrophic healthcare attention was way below in their priority list, what with the struggle for basic survival. The political class invested in development where they could maximize their political returns; their concern was for vote-banks and hence the focus of development programmes (not rights) was in 'rural development', 'infrastructure development' and development through 'reservations'. Rural development programmes helped direct agricultural growth with the goal of achieving self-sufficiency in basic food production. In reality the middle and the rich peasantry benefited and the small peasantry and landless remained under the illusion that their turn in development was next. Infrastructure development helped create space and conditions for their growth, and the reservation policies appeased the oppressed minorities.

With this kind of a development strategy key social development issues like health, education, and housing got sidelined and never became 'political' issues which would drive the development strategy. Planned development without a rights based approach can only yield limited results and outcomes. For issues to become sustainable political agendas, they must be contextualised in the rights domain. The right to health and healthcare too cannot be realized through the current development agenda. It has to be constituted as an independent right, like the right to life in Article 21 of the Constitution of India and/ or through a legislative mandate with clear resource commitments.

Health Care System

The Constitution has made health care services largely a responsibility of State governments but has left enough manoeuvrability for the Centre since a large number of items are listed in the concurrent list. The Centre has been able to expand its sphere of control over the health sector.[1] Hence the central government has played a far more significant role in the health sector than demanded by the Constitution. The health policy and planning framework has been provided by the central government. In concrete terms, the central government has pushed various national programmes (vertical programmes for leprosy, tuberculosis, blindness, malaria, smallpox, diarrhoea, filaria, goitre and now HIV/AIDS) in which the States have had little say. The States have acquiesced due to the central government's accompanying funding. These programmes are implemented uniformly across the length and breadth of the country. Then there are the Centre's own programmes of family planning and universal immunization which the states have to implement. In sum, central government intervention in the state's domain of health care activities is an important feature that needs to be considered in any analysis of public health care services.

The distribution of health care services is skewed favouring urban areas. Large cities, depending on their population have a few state- run hospitals (including teaching hospitals). At the district level on an average there is a 150 bedded Civil General Hospital in the main district town and a few smaller hospitals and dispensaries spread over the other towns in the district and sometimes in large villages. In the rural areas of the district there are rural hospitals, primary health centres (PHCs) and sub-centres that provide various health services and outreach services.

For the country as a whole presently there are an estimated 22,000 hospitals (30 per cent rural), 23,000 dispensaries (50 per cent rural) and about 1.5 million beds (21per cent rural) (Table A). The rural areas in addition have 23,500 PHCs and 140,000 sub-centres. However, when this data is represented proportionately to its population we see that urban areas have 4.48 hospitals, 6.16 dispensaries and 308 beds per 100,000 urban population in sharp contrast to rural areas which have 0.77 hospitals, 1.37 dispensaries, 3.2 PHCs and 44 beds per 100,000 rural population. The city hospitals and the civil hospitals are basically curative centres providing outpatient and in-patient services for primary, secondary and tertiary care. In contrast the rural institutions provide mainly preventive and promotive services like communicable disease control programmes, family planning services and immunization services. Curative care in the rural health

[1] The Constitutional provisions (Schedule 7 of article 246) are classified into three lists, including a Concurrent list which both centre and states can govern but with the overriding power remaining with the centre. The list here includes original entry numbers **Central List:** 28.Port quarantine, including hospitals connected therewith; seamen's and marine hospitals 55.Regulation of labour and safety in mines and oilfields; **State List:** 6.Public health and mental deficiency, including places for the reception or treatment of lunatics and mental deficients 18.Adulteration of foodstuffs and other goods. 19. Drugs and poisons, subject to the provisions of entry 59 of List I with respect to opium 20A.Population control and family planning 23.Social security and social insurance; employment and unemployment. 24.Welfare of labour including conditions of work, provident funds, employers' liability, workmen's compensation, invalidity and old age pensions and maternity benefits 25.Education, including technical education, medical education and universities, subject to the provisions of entries 63, 64, 65 and 66 of List I; vocational and technical training of labour.] 26. Legal, medical and other professions 30.Vital statistics including registration of births and deaths. (http://alfa.nic.in/const/schedule.html)

institutions are the weakest component even though there exists a high demand for such services. This demand is met either by the city hospitals or by private practitioners.

Medical education is imparted largely through state-owned/funded institutions at highly subsidized costs. There are 195 recognized allopathic medical colleges in the country producing over 20,000 medical graduates every year 75 per cent of whom are from public institutions. However, the outturn from these institutions does not benefit the public health services because 80 per cent of the outturn from public medical schools either joins the private sector or migrates abroad.

The private health sector in India is very large. In 2002 an estimated 62 per cent of hospitals, 54 per cent dispensaries and 35 per cent of beds were in the private sector (Table A). An estimated 75 per cent of allopathic doctors are in the private sector and about 80 per cent are individual practitioners. Over 90 per cent of non-allopathic doctors work in the private sector. Private health services, especially the general practitioners, are the single largest category of health care services utilized by the people. There also exist a large number of unqualified practitioners in urban and rural areas in the private sector whose services are well utilized, but their actual numbers are not known. Available data show that in 2004 there were over 660,000 registered allopathic doctors and over 780,000 registered non-allopathic doctors. Of the 1.4 million doctors about 1.2 million are estimated to be in the private sector.

The private health sector, especially the allopathic, constitutes an influential lobby in policy-making circles in India. There is virtually no regulation of this sector. The medical councils of the various systems of medicine perform only the function of registering qualified doctors and issuing them the license to practice. There is no monitoring, continuing education, price regulation, prescription vetting etc., either by the medical councils or the government. It has not been possible to implement progressive policy initiatives, such as the recommendation of the Hathi Committee Report[2] Pharmaceutical formulation production in India is presently worth over Rs. 280 billion and over 98 per cent of this is in the private sector.

How does all this impact on health outcomes, especially among the poor? In Table A we see substantial improvements in health outcomes such as IMR, CBR, CDR and life expectancy over the years. But India's global rank vis-à-vis these indicators has not changed. In fact the latest Human Development Report shows a downward trend in India's global ranking.[3]

This slowing of growth in India's human development score is perhaps linked to the declining investments and expenditures in the public health sector (as also the social sectors as a whole), especially in the 1990s. In the mid- 1980s public health expenditure had peaked because of the large expansion of the rural health infrastructure but after 1986 one witnesses a declining trend in both new investments as well as expenditures as a proportion to the GDP, and as a percent of government's overall expenditures. [Duggal et.al., 1995 and Duggal, 2002]. In sharp contrast out-of-pocket expenses that go largely to the private health sector, have witnessed unprecedented increases. (See Table A)

---

[2] The Hathi Committee's recommendations pertained to removal of irrational drug combinations, generic naming of essential drugs and development of a National Formulary for prescription practice.

[3] India's human development index rank is down from 115 in 1999 to 124 in 2000 and 127 in 2001, though still better than the 1994 rank of 138. It is on the fringe of medium and low HDI group of countries. India's improvement in the HDI in the last 26 years has been marginal from a score of 0.407 in 1975 to 0.590 in 2001 - working out to an average increase of 1.7 per cent per annum. The slowing down of growth is shown in the table below: [UNDP HDR, various years]

	1975	1980	1985	1990	1995	2000
HDI score	0.407	0.434	0.473	0.511	0.545	0.577
Annual % increase over previous period	—	1.3	1.8	1.6	1.3	1.1

Table A: Health Care Development in India, 1951-2004

			1951	1961	1971	1981	1991	1996	1997	2001-02	Latest**
1	Hospitals*	Total	2694	3054	3862	6805	11174	15170	15188	18436	22000
		Per cent Rural	39	34	32	27		34	34	30	30
		Per cent Private				43	57	68	68	62	75
2	Hospital & dispensary beds*	Total	117000	229634	348655	504538	806409	892738	896767	914543	1500000
		Per cent Rural	23	22	21	17		23	23	21	21
		Per cent Private				28	32	37	37	35	50
3	Dispensaries*		6600	9406	12180	16745	27431	25653	25670	22291	
		Per cent Rural	79	80	78	69		41	40	50	
		Per cent Private				13	60	57	56	54	
4	PHCs		725	2695	5131	5568	22243	21917	22446	22842	23500
5	Sub-centres				27929	51192	131098	134931	136379	137311	140000
6	Doctors	Allopaths	60840	83070	153000	266140	393640	462745	496941	605840	660000
		All Systems	156000	184606	450000	665340	920000		1080173	1297310	1430000
7	Nurses		16550	35584	80620	150399	311235	565700	607376	805827	880000
8	Medical colleges	Allopathy	30	60	98	111	128	165	165	189	195
9	Out turn	Graduates	1600	3400	10400	12170	13934				20000
		Postgrad-uates		397	1396	3833	3139		3656		6000
10	Pharmaceutical production	Rs. in billion	0.2	0.8	3	14.3	38.4	91.3	104.9	220	280
11	Health outcomes	IMR/000	134	146	138	110	80	72	71	66	65
		CBR/000	41.7	41.2	37.2	33.9	29.5	27	27	25	24
		CDR/000	22.8	19	15	12.5	9.8	9	8.9	8.1	8
	Life Expectancy	years	32.08	41.22	45.55	54.4	59.4	62.4	63.5	64.8	65
	Births attended by trained practitioners	Percent				18.5	21.9	28.5			
12	Health Expenditure Rs. Billion	Public	0.22	1.08	3.35	12.86	50.78	101.65	113.13	211	249
		CSO private		2.05	6.18	29.7	82.61	329	373.41	1100	1464
	Health Expenditure as percent of GDP	Public	0.25	0.71	0.84	1.05	0.92	0.91	0.88	0.89	0.91
		Private CSO		1.34	1.56	2.43	1.73	2.95	3	5.32	5.4
	Health Expenditure as % to Govt. Total	Public	2.69	5.13	3.84	3.29	2.88	2.98	2.94	2.72	2.6

*Data on hospitals, dispensaries and beds pertaining to the private sector is grossly under reported and figures for 2001-02 for public facilities also suffers from under-reporting as a number of states do not send up-to-date information. Thus the actual figures should be much higher, and especially so for the private sector
**Latest years – rounded figures are estimates by author and figures pertain to years 2003/2004

Source : 1. Health Statistics / Information of India, CBHI, GOI, various years; 2. Census of India Economic Tables, 1961, 1971, 1981, GOI 3.OPPI Bulletins and Annual reports of Min. of Chemicals and Fertilisers for data on Pharmaceutical Production 4. Finance Accounts of Central and State Governments, various years 5. National Accounts Statistics, CSO, GOI, various years 6. Statistical Abstract of India, GOI, various years 7. Sample Registration System - Statistical Reports, various years 8. NFHS - 2, India Report, IIPS, 2000

Human Right to Health and Healthcare[4]

Constitutional and Legal Dimensions

India joined the UN at the start on October 30th 1945 and on December 12th 1948 when the Universal Declaration of Human Rights (UDHR) was proclaimed, India was a party to this. The formulation of India's Constitution was certainly influenced by the UDHR and this is reflected in the Fundamental Rights and the Directive Principles of State Policy. Most of the civil and political rights are guaranteed under the Indian Constitution as Fundamental Rights. But most of the Economic, Social and Cultural Rights do not have such a guarantee. The Constitution makes a forceful appeal to the State through the Directive Principles to work towards assuring these rights through the process of governance but clearly states that any court cannot enforce them.[5]

The experience of governance in India shows that both Fundamental Rights and Directive Principles have been used as a political tool. While the Fundamental Rights are justiciable, and on a number of occasions citizens and courts have intervened to uphold them, there have also been numerous instances where even the courts have failed either because the ruling government has steamrolled them or the court orders have been ignored. In case of the Directive Principles it is mostly political mileage, which determines which of the principles get addressed through governance. For instance, Article 46[6] has been implemented with a fair amount of seriousness through the policy of reservations for scheduled caste, tribes and other backward castes/classes because it is the most powerful tool for success in India's electoral politics. But Articles 41, 42 and 47, which deal with social security, maternity benefits and health, respectively, have been addressed only marginally.

When we look at right to health and healthcare in the legal and constitutional framework, it is clearly evident that the Constitution and laws of the land do not in any way accord health and healthcare the status of rights. There are instances in case law where, for instance the right to life, Article 21 of

---

[4] The debate on terminology of 'Right to Health' and 'Right to Healthcare' is endless and we will not get into this here.. Suffice to say that right to health is not independent of right to healthcare and hence they must be seen in tandem. The WHO definition was influenced largely by Sigerist, who argued that state of health is a physical, mental and social condition and "health is, therefore, not simply the absence of disease – it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts on the individual" [Sigerist, 1941, p.68]. This broad definition, including social well-being is often criticised for being too broad and as a consequence the concern for access to healthcare is lost. However Sigerist also emphasized that healthcare protection and provision was the right of the citizen and it was the state's duty to respect this. The focus in this paper is on the right to access healthcare and other related rights, and as a consequence, health. Hence, the use of the phrase 'right to health and healthcare'... For a debate on the definitions and further references see Toebes(1998).

[5] Article 37 pertaining to the application of the principles contained in Part IV of the constitution states, "The provisions contained in this Part shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws"

[6] Article 46 - Promotion of educational and economic interests of Scheduled Castes, Scheduled Tribes and other weaker sections: The State shall promote with special care the educational and economic interests of the weaker sections of the people, and, in particular, of the Scheduled Castes and the Scheduled Tribes, and shall protect them from social injustice and all forms of exploitation.

the Constitution, or various Directive Principles have been used to demand access to healthcare, especially in emergency situations or references made to the International Covenants.

These are exceptional cases, and even if the Supreme Court or the high courts have upheld some decisions as being a right, for instance getting at least first aid in emergency situations from private clinics or hospitals, or access to public medical care as a right in life threatening situations, or right to healthy and safe working environment and medical care for workers etc., the orders are rarely respected in day to day practice unless one goes back to the courts to reiterate the orders. In fact, this is often the case even with Fundamental Rights, which the State has failed to respect, protect, or fulfil as a routine, and one has to go to the courts to demand them. For a population, which is predominantly at the poverty or subsistence level, expecting people to go to the courts to seek justice for what is constitutionally ordained as a right is unrealistic as well as discriminatory. The mere constitutional provision is not a sufficient condition to guarantee a right, and more so in a situation like health and healthcare wherein provisions in the form of services and commitment of vast resources are necessary to fulfil the right.

Despite the above, it is still important to have health and healthcare instituted as a right within the Constitution and/or established by a specific Act of Parliament guaranteeing the right. Ruth Roemer discussing this issue writes, "The principal function of a constitutional provision for the right to health care is usually symbolic. It sets forth the intention of the government to protect the health of its citizens. A statement of national policy alone is not sufficient to assure entitlement to health care; the right must be developed through specific statutes, programs and services. But setting forth the right to health care in a constitution serves to inform the people that protection of their health is official policy of the government and is reflected in the basic law of the land".

To take an example, government policy vis-à-vis healthcare services has mandated entitlements under the Minimum Needs Programme started with the Fourth Five Year Plan. Each district should have a civil hospital in each district, a primary health centre in rural areas for each 20,000 –30,000 population (depending on population density and difficulty of terrain) and five such units supported by a 30 bedded Community Health Centre (CHC), a sub centre with two health workers for a rural population unit of 2500-5000 population, and similarly a Health Post for 50,000 persons in urban areas. But what is the real situation? No district (except perhaps the very new ones) has a civil hospital (and each district did have a civil hospital even during the colonial period!). The situation regarding PHCs varies a lot across states from 1 per 7000 rural population in Mizoram to 1 per over 100,000 in some districts of the EAG[7] states. The villagers deprived of this entitlement cannot go to the courts demanding the right to a PHC for their area because such a legal backing does not exist. Further, in many states where this ratio is honoured for PHCs or CHCs, adequate staff, medicines, diagnostic facilities, maintenance budgets are often not available to assure that proper provision of services is available to the people accessing these services [MoHFW, 2001]. Further still, if one looks at distribution of healthcare resources across regions, rural and urban areas, one sees vast discrimination – in metropolitan areas public health budgets range from Rs.500-1300 per capita in sharp contrast to PHC areas with only Rs. 40-120 per capita; urban areas across the country have a bed-population ratio of over 300 beds per 100,000 population in contrast to rural areas having around 40 beds per 100,000 persons. This is gross inequity but there is no law presently that can help address this.

Apart from the above a small privileged section of the population, largely what is called the organized sector, that is those working in government, private industry and services have some form of health/social insurance coverage, either through

[7] EAG stands for Empowered Action Group states which include Rajasthan, Madhya Pradesh, Chattisgarh, Uttar Pradesh, Uttaranchal, Bihar, Jharkhand and Orissa

social security legislation like Employee State Insurance Scheme, Central Government Health Scheme, Maternity Benefit Scheme, and various other schemes for mine workers, plantation workers, beedi workers, cinema workers, seamen, armed forces, railway employees etc., or through employer provided health services or reimbursements. This population estimated to be about 12 per cent of the country's population might be said to have right to healthcare, at least during the working life of the main earner in the family. Another 1per cent of the population is covered through private health insurance like Mediclaim [Ellis, Randal et.al, 2000]. In these cases entitlement is based on employment of a certain kind, which provides rights on the basis of protective legislation that is not available to the general population. While this is a positive provision, it becomes discriminatory because the entitlement as a right is selective and not universal. Mere entitlements having basis only in policy or as selective rights does not establish a right and neither can assure equity and non-discrimination.

At the global level the International Covenant on Economic, Social and Cultural Rights (ICESCR) mandates right to health through Article 9 and Article 12 of the covenant:

Article 9
The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance.

Article 12
1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions, which would assure to all medical service and medical attention in the event of sickness.

Also Articles 7 and 11 include health provisions: "The States Parties ... recognize the right of everyone to ... just and favourable conditions of work which ensure ... safe and healthy working conditions; ... the right to ... an adequate standard of living."

India ratified this Covenant on 10th April 1979, and having done that became obligated to take measures to assure health and healthcare (among others) as a right. As per Articles 2 and 3 of this covenant States ratifying this treaty are obligated to:

Article 2
1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.
2. The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

Article 3
The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

It is now over 25 years since India committed to this treaty. Post-ratification efforts through the

Sixth Five-year Plan and the first National Health Policy in 1982 were indeed the first steps in honouring this commitment. As we have seen above, the rural public health infrastructure was expanded considerably during the first half of the 'Eighties, more resources were being committed to the health sector etc., but somewhere by the mid- Eighties the commitment seems to have lost ground. In the 1990s with the economic crises the public health sector lost out completely, with the final blow being delivered by the National Health Policy 2001. Interestingly, the last decade of the 20th century also saw the declining commitment to Health For All by the WHO, when in the 1998 World Health Assembly it announced its policy for Health for All in the 21st Century. WHO had started toeing the World Bank line from the 1993 World Development Report (WDR) Investing in Health, which asked poor country/developing country governments to focus on committing public resources to selective care for selected/targeted populations, and to leave the rest to the market. With inter-governmental commitment to assure the right to the highest attainable standard of health waning, it became even more difficult for the Indian State to honour its commitment to ICESCR in an economic environment largely dictated by the World Bank. At another level the Committee of the Economic, Social and Cultural Rights, which is supposed to monitor the implementation of ICESCR, has also failed to get countries like India to take measures to implement the provisions of the ICESCR. India has submitted its combine 2nd, 3rd, 4th & 5th periodic report to UN in October 2006.[8]

Following are other international laws, treaties and declarations, which India is a party to and which have a bearing on the right to health. Provisions in most of these also relate to Fundamental Rights and Directive Principles of the Indian Constitution as well as relate to many policy initiatives taken within the country.[9]

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger. Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development. The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health. Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people. Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures. - **WHO Constitution**

> "Everyone has the right to a standard of living adequate for ... health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of ... sickness, disability.... Motherhood and childhood are

---

[8] The report is available at http://www.ohchr.org

[9] For instance, the impact of CEDAW, Cairo and Beijing Declarations is closely linked to the formulation of a policy on women and women's empowerment, and setting up of the national and state Commissions on Women, the Rashtriya Mahila Kosh and of formulation of many development programs for women like DWACRA, savings and credit programs etc... Similarly the various human rights treaties like those dealing with racial discrimination, torture, civil and political rights etc.and the UNCHR have been instrumental in India setting up the National and State Human Rights Commissions. The NHRC has presently set up a separate cell to monitor ICESCR as also for right to public health.

entitled to special care and assistance...." - **Universal Declaration of Human Rights, Article 25**

"States Parties shall ... ensure to [women] ... access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.... States Parties shall ... eliminate discrimination against women in ... health care ... to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning....; ensure ... appropriate services in connection with pregnancy.... States Parties shall ... ensure ... that [women in rural areas] ... have access to adequate health care facilities, including information counselling and services in family planning...." - **Convention on the Elimination of All Forms of Discrimination Against Women, Articles 10, 12, and 14**

"States Parties undertake to ... eliminate racial discrimination ... and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, ... the right to public health, medical care, social security and social services...." -**Convention on the Elimination of All Forms of Racial Discrimination, Article 5**

"States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health...." - **Convention on the Rights of the Child, Article 24**

In the 1977 World Health Assembly member states pledged a commitment towards a health for all strategy, "... the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life..." (AL Taylor –Making the World Health Organisation Work : A legal framework for universal access to the conditions for Health, American Journal of Law and Medicine, Vol 18 No. 4, 1992, 302). At the International conference which followed in 1978 at Alma Ata this was converted into the famous primary health care declaration whereby Governments would be responsible to the people to assure primary health care for all by the year 2000. Primary health care is "essential health care which is to be universally accessible to individuals and families in the community in ways acceptable to them, through their full participation at a cost the community can afford" (WHO, Primary Health Care, 1978, p. 3) - **Alma Ata Declaration on Health For All by 2000**

"Health and development are intimately interconnected. Both insufficient development leading to poverty and inappropriate development ... can result in severe environmental health problems.... The primary health needs of the world's population ... are integral to the achievement of the goals of sustainable development and primary environmental care.... Major goals ... By the year 2000 ... eliminate guinea worm disease...; eradicate polio... By 1995 ... reduce measles deaths by 95 per cent...; ensure universal access to safe drinking water and ... sanitary measures of excreta disposal...; By the year 2000 [reduce] the number of deaths from childhood diarrhoea ... by 50 to 70 per cent..." - **Agenda 21,Chapter 6, paras. 1 and 12**

"Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care.... The role of women as primary custodians of family health should be recognized and supported. Access to basic health care, expanded health education, the availability of simple cost-effective remedies ... should be provided...." - **Cairo Programme of Action, Principle 8 and para. 8.6**

"We commit ourselves to promoting and attaining the goals of universal and equitable access to ... the highest attainable standard of physical and mental health, and the access of all to primary health care, making particular efforts to rectify inequalities relating to social conditions and without distinction as to race, national origin, gender, age or disability...." - **Copenhagen Declaration, Commitment 6**

"The explicit recognition ... of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.... We are determined to ... ensure equal access to and equal treatment of women and men in ... health care and enhance women's sexual and reproductive health as well as Health." - **Beijing Declaration, paras. 17 and 30**

"Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life.... Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology.... To attain optimal health ... equality, including the sharing of family responsibilities, development and peace are necessary conditions." - **Beijing Platform for Action, para. 89**

"Strategic objective ... Increase women's access throughout the life cycles to appropriate, affordable and quality health care, information and related services.... Actions to be taken: ... Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation...; Provide more accessible, available and affordable primary health care services of high quality, including sexual and reproductive health care...; Strengthen and reorient health services, particularly primary health care, in order to ensure universal access to health services...; reduce maternal mortality by at least 50 per cent of the 1990 levels by the year 2000 and a further one half by the year 2015;... make reproductive health care accessible ... to all ... no later than ... 2015...; take specific measures for closing the gender gaps in morbidity and mortality where girls are disadvantaged, while achieving ... by the year 2000, the reduction of mortality rates of infants and children under five ... by one third of the 1990 level...; by the year 2015 an infant morality rate below 35 per 1,000 live births.... Ensure the availability of and universal access to safe drinking water and sanitation...." - **Beijing Platform for Action, para. 106**

"Human health and quality of life are at the centre of the effort to develop sustainable human settlements. We ... commit ourselves to ... the goals of universal and equal access to ... the highest attainable standard of physical, mental and environmental health, and the equal access of all to primary health care, making particular efforts to rectify inequalities relating to social and economic conditions ..., without distinction as to race, national origin, gender, age, or disability. Good health throughout the life span of every man and woman, good health for every child ... are fundamental to ensuring that people of all ages are able to ... participate fully in the social, economic and political processes of human settlements.... Sustainable human settlements depend on ... policies ... to provide access to food and nutrition, safe drinking water, sanitation, and universal access to the widest range of primary health-care services...; to eradicate major diseases that take a heavy toll of human lives, particularly childhood diseases; to create safe places to work and live; and to protect the environment.... Measures to prevent ill health and disease are as important as the availability of appropriate medical treatment and care. It is therefore essential to take a holistic approach to health, whereby both prevention and care are placed within the context of environmental policy...." - **Habitat Agenda, paras. 36 and 128**

International law apart, as discussed earlier, provisions within the Indian Constitution itself exist to give the people of India right to healthcare. Articles 41, 42 and 47 of the Directive Principles[10] enshrined in Part IV of the Constitution provide the basis to evolve right to health and healthcare:

Article 41. Right to work, to education and to public assistance in certain cases: The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.

Article 42. Provision for just and humane conditions of work and maternity relief: The State shall make provision for securing just and humane conditions of work and for maternity relief.

Article 47. Duty of the State to raise the level of nutrition and the standard of living and to improve public health: The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.

Thus social security, social insurance, decent standard of living, and public health coupled with the policy statements over the years, which in a sense constitutes the interpretation of these constitutional provisions, and supported by international legal commitments, form the basis to develop right to health and healthcare in India. The only legal/constitutional principle missing is the principle of justiciability. In the case of education the 93rd amendment to the Constitution has provided limited justiciability. With regard to healthcare there is even a greater need to make such gains because often in the case of health it is a question of life and death. As stated earlier, for a small part of the working population right to healthcare through the social security/social insurance route exists. This means that such security can be made available to the general population too. That a few people enjoy this privilege is also a sign of discrimination and inequity that violates not only the non-discrimination principle of international law, but it also violates Article 14 of the Constitution, Right to Equality, under the chapter of Fundamental Rights.

With regard to the question of justiciability of international law, like Britain, India follows the principle of dualism. This means that for international law to be applicable in India, it needs to be separately legislated. Since none of the international human rights treaties have been incorporated or transformed into domestic laws in India, they have only an evocative significance and may be used by the Courts or petitioners to derive inspiration [Nariman, 1995]. Thus on a number of occasions many of these human right treaties ratified in India, have been used by the Indian Courts in conjunction with Fundamental Rights.[11] International law has its importance in providing many principles but in India's case, there is substantial leeway within our own legal framework on right to health and healthcare. The emphasis needs to shift to critical principles as laid down in the directive principles. This is the only way of bringing right to health and healthcare on the national agenda, even as the support of international treaties will play a role in cementing this demand.

---

[10] "The courts are much more aware of and attentive towards their obligation to implement socio-economic uplift programmes and to ensure decent welfare for all. The state has a duty to all citizens to adhere to that part of the Constitution, which describes the directive principles as 'fundamental' to the governance of the country. The courts have therefore been using the directives as an instrument to determine the extent of public interest in order to limit the extension of fundamental rights. In doing so they have upheld a number of statutes on the grounds of public interest, which in other circumstances may have been nullified." (De Villiers, 1992).

[11] In a judgment on sexual harassment at the work place, in which the CEDAW and Beijing Declaration was invoked, the Supreme Court outlined this approach as follows – Any international convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into these provisions to enlarge the meaning and content thereof, to promote the object of the constitutional guarantee (Vishaka v/s State of Rajasthan, writ petition number 666-70 of 1992, quoted in Toebes, 1998)

Framework for Right to Health and Healthcare

Health and health care is now being viewed very much within the rights perspective and this is reflected in Article 12 'The right to the highest attainable standard of health' of the International Covenant on Economic, Social and Cultural Rights. According to the General Comment 14 the Committee for Economic, Social and Cultural Rights states that the right to health requires availability, accessibility, acceptability, and quality with regard to both health care and underlying preconditions of health. The Committee interprets the right to health, as defined in Article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. This understanding is detailed below:

The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

(a) ***Availability.*** Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) ***Accessibility.*** Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination:health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) ***Acceptability.*** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) ***Quality.*** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. (Committee on Economic, Social and Cultural Rights Twenty-second session 25 April-12 May 2000)

Universal access to good quality healthcare equitably is the key element at the core of this understanding of right to health and healthcare. To make this possible the State parties are obligated to respect, protect and fulfill the above in a progressive manner:

The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to respect protect and fulfil. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfil requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. (Ibid)

States parties are referred to the Alma-Ata Declaration, which proclaims that the existing gross inequality in the health status of the people, particularly between developed and developing countries, as well as within countries, is politically, socially and economically unacceptable and is, therefore, of common concern to all countries. States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
(b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(e) To ensure equitable distribution of all health facilities, goods and services;
(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

The Committee also confirms that the following are obligations of comparable priority:
(a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
(b) To provide immunization against the major infectious diseases occurring in the community;
(c) To take measures to prevent, treat and control epidemic and endemic diseases;
(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
(e) To provide appropriate training for health personnel, including education on health and human rights. (Ibid)

The above guidelines from General Comment 14 on Article 12 of ICESCR are critical to the development of the framework for right to health

and healthcare. As a reminder it is important to emphasise that in the Bhore Committee report of 1946 we already had these guidelines, though they were not in the 'rights' language. Thus within the country's own policy framework all this has been available as guiding principles for now 60 years.

Where does India stand today vis-à-vis the core principles of availability, accessibility, acceptability and quality in terms of the State's obligation to respect, protect and fulfil?

To sum up from the earlier section, healthcare infrastructure, except perhaps availability of doctors and drugs is grossly inadequate. Then there are the underlying conditions of health and access to factors that determine this, which are equally important in a rights perspective. Given the high level of poverty and even a lower level of public sector participation in most of these factors, the question of the State respecting, protecting and fulfilling them is quite remote.

Besides this environmental health conditions in both rural and urban areas are quite poor, working conditions in most work situations, including many organized sector units, which are governed by various social security provisions, are unhealthy and unsafe. In fact, most of the court cases using Article 21 of the Fundamental Rights and relating it to right to health have been cases dealing with working conditions at the workplace, workers rights to healthcare and environmental health related to pollution these will be dealt with in the following chapters.

Other concerns in access are the question of economic accessibility. It is astounding that large-scale poverty and predominance of private sector in healthcare co-exist. This contradiction reflects the State's failure to respect, protect and fulfil its obligations by letting vast inequities in access to healthcare and vast disparities in health indicators, to continue to persist, and in many situations get worse. Data shows that out of pocket expenses account for over 4 per cent of the GDP as against only 0.9 per cent of GDP expended by state agencies, and the poorer classes contribute a disproportionately higher amount of their incomes to access health care services both in the private sector and public sector [Ellis, et.al, 2000; Duggal, 2000; Peters et.al. 2002]. Further, the better off classes use public hospitals in much larger numbers with their hospitalization rate being six times higher than the poorest classes,[12] and as a consequence consume an estimated over three times more of public hospital resources than the poor [NSS-1996; Peters et.al. 2002].

Related to the above is another concern vis-à-vis international human rights conventions' stance on matters with regard to provision of services. All conventions talk about affordability and never mention free of charge services. In the context of poverty this notion is questionable as far as provisions for social security like health, education and housing go. Access to these factors socially has unequivocal consequences for equity, even in the absence of income equity. Free services are viewed negatively in global debate, especially since we have had a unipolar world, because it is deemed to be disrespect to individual responsibility with regard to their healthcare [Toebes, 1998, p.249]. For instance in India there is great pressure on public health systems to introduce or enhance user fees, in the belief that they will enhance responsibility of the public health system and make it more efficient [Peters, et. al.]. In many states that have adopted such a policy the immediate adverse impacts are seen, the most prominent being decline in utilization of public services by the poorest. It is unfortunate that the Tenth Five Year Plan draft document supports raising more resources by increasing user charges in secondary and tertiary hospitals. India's taxation policy favours the richer classes. Direct tax revenues, like income tax is a very small proportion of total tax revenues. Hence the poor end up paying a larger proportion of their income as tax revenues in the form of sales tax, excise duties etc. on goods and services they consume. Viewed from this perspective the poor have already pre-paid for receiving public goods like health and education from the state free of cost at the point of provision.

[12] The poorer classes have reported such low rates of hospitalization, not because they fall ill less often but because they lack resources to access healthcare, and hence invariably postpone utilization of hospital services until it is absolutely unavoidable.

So their burden of inequity increases substantially if they have to pay for such services when accessing from the public domain.

The above inequity in access gets reflected in health outcomes, which too, reflect strong class gradients. In India there is an additional dimension to this inequity – differences in health outcomes and access by social groups, specifically the scheduled castes and scheduled tribes. Data show that these two groups are worse off than others on all counts. Thus in access to hospital care as per NSS 1996 data the STs had 12 times less access in rural areas and 27 times less in urban areas than others; for SCs the disparity was four and nine times, in rural and urban areas, respectively. They fare worse even in urban areas where overall physical access is reasonably good. Their health outcomes 1.5 times more adverse than others [NFHS 1998].

Another stumbling block in meeting state obligations is information access. While data on public health services, with all its limitations, is available, data on and from the private sector is conspicuous by its absence. For one, the size of the private sector is an under-estimate as occasional studies have shown.[13] Medical councils of all systems of medicine are statutory bodies but they have been unable to regulate medical practice and prevent unqualified and untrained practitioners. The private sector does not meet its obligations to supply data on notifiable, mostly communicable, diseases, which is mandated by law adversely affecting the epidemiological database for those diseases as also public health practice and monitoring drastically.

Finally there are issues pertaining to acceptability and quality. Here the Indian state fails totally. There is a clear rural-urban dichotomy in health policy with urban areas enjoying comprehensive healthcare services through public hospitals and dispensaries and now, preventive inputs and in contrast rural areas with poor curative services. This violates the principle of non-discrimination and equity and hence is a major ethical concern to be addressed.

Medical practice, especially private, suffers from a complete absence of ethics. There has been poor regulation of malpractices in medical practice. There exist no standard protocols for clinical practice making the monitoring of quality difficult. For hospitals the Bureau of Indian Standards has developed guidelines, and often public hospitals do follow these guidelines [Nandraj and Duggal, 1997]. But in the case of private hospitals they are generally ignored. Recently efforts at developing accreditation systems has been started in Mumbai [Nandraj, et.al, 2000],[14] and on the basis of that the Central government is considering measures at the national level on this front so that it can promote quality of care. The pharmaceutical industry plays a major role in encouraging irrational practices.[15]

References

1. Andreassen, B, Smith, A and Stokke, H, (1992): Compliance with economic and Social Rights: Realistic Evaluations and Monitoring in the Light of Immediate Obligations in A Eide and B Hagtvet (eds) Human Rights in Perspective: A Global Assessment, Blackwell, Oxford
2. Bhore, Joseph,(1946) : Report of the Health Survey and Development Committee, Volume I to IV, Govt. of India, Delhi

[13] A survey in Mumbai in 1994 showed that the official list with the Municipal Corporation accounted for only 64per cent of private hospitals and nursing homes [Nandraj and Duggal, 1997]. Similarly, a much larger study in Andhra Pradesh in 1993 revealed extraordinary missing statistics about the private health sector. For that year official records indicated that AP had 266 private hospitals and 11,103 beds, but the survey revealed that the actual strength of the private sector was over ten times more hospitals with a figure of 2802 private hospitals and nearly four times more hospital beds at 42192 private hospital beds. [Mahapatra, P, 1993].

[14] In Mumbai CEHAT in collaboration with various medical associations and hospital owner associations has set up a non-profit company called Health Care Accreditation Council. It hopes to provide the basis for evolving a much larger initiative on this front.

[15] Data of 80 top selling drugs in 1991 showed that 29per cent of them were irrational and/or hazardous and their value was to the tune of Rs. 2.86 billion. A study of prescription practice in Maharashtra in 1993 revealed that outright irrational drugs constituted 45per cent of all drugs prescribed and rational prescriptions were only 18per cent. The proportion of irrationality was higher in private practice by over one-fifth. (Phadke, 1998)

3. CBHI, various years : Health Information of India, Central Bureau of Health Intelligence, MoHF&W, GOI, New Delhi
4. De Villiers (1992) 'Directive Principles of State Policy and Fundamental Rights: The Indian Experience', *South African Journal on Human Rights* 29 (1992).
5. Duggal, Ravi, Nandraj S, Vadair A (1995): Health Expenditure Across States, Economic and Political Weekly, April 15 and April 22, 1995
6. Duggal, Ravi (2000): The Private Health Sector in India – Nature, Trends and a Critique, VHAI, New Delhi
7. Ellis, Randall, Alam, Moneer and Gupta, Indrani (2000): Health Insurance in India – Prognosis and Prospectus, Economic and Political Weekly, Jan.22, 2000
8. FYP I – IX, various years: Five Year Plans – First to Ninth, Planning Commission, GOI, New Delhi
9. Gupta, RB et.al.(1992) : Baseline Survey in Himachal Pradesh under IPP VI and VII, 3 Vols., Indian Institute of Health Management Research, Jaipur
10. Hathi Committee, 1975: Committee of Drugs and Pharmaceutical Industry, Ministry of Chemicals and Petroleum, GOI, New Delhi
11. Hernan L. Fuenzalida-Puelma/Susan Scholle Connor, eds (1989): *The Right to Health in the Americas Pan-American Health Organization*, Scientific Publication No. 509, Washington, D.C)
12. ICMR (1990): A National Collaborative Study of High Risk Families - ICMR Task Force, New Delhi
13. MoCF (2001): Annual report, Dept. of Chemicals and Petrochemicals, Ministrof Chemicals and Fertilizers, GOI, New Delhi
14. MoHFW (1983) : National Health Policy, Govt. of India, Ministry of Health & Family Welfare, New Delhi
15. MoHFW (2001): India Facility Survey Phase I, 1999, IIPS, Ministry of Health and Family Welfare, New Delhi
16. Nandraj, Sunil and Ravi Duggal (1997) : Physical Standards in the Private Health Sector, Radical Journal of Health (New Series) II-2/3
17. Nariman, F1(1995): Economic Social and Cultural Rights and the Role of Lawyers, *ICJ Review* No. 55, 1995
18. NFHS-1998 (2000): National Family Health Survey –2: India, IIPS, Mumbai
19. NHP-2001: Draft National Health Policy, Ministry of Health and Family Welfare, GOI, New Delhi
20. NSS-1987 : Morbidity and Utilisation of Medical Services, 42nd Round, Report No. 384, National Sample Survey Organisation, New Delhi
21. NSS-1996 (2000) : Report No. 441, 52nd Round, NSSO, New Delhi, 2000
22. OECD (1990) : Health Systems in Transition, Organisation for Economic Cooperation and Development, Paris
23. Phadke, Anant (1998): *Drug Supply and Use – Towards a Rational Policy in India*, Sage, New Delhi
24. Rhode, John and Vishwanathan, H (1994): The Rural Private Practitionero, Health for the Millions, 2:1, 1994
25. Sigerist, H (1941*): Medicine and Human Welfare*, Oxford Univ. Press, London
26. Simon Committee (1960): National Water Supply and Sanitation Committee, GOI, New Delhi
27. Toebes, Brigit (1998): *The Right to Health as a Human Right in International Law*, Intersentia – Hart, Antwerp
28. UNDP (2003): *Human Development Report 2002*, UNDP, NY (also years 1990-2001)
29. WHO, 1988 : Country Profile - India, WHO - SEARO, New Delhi
30. WHO, 1988 a: Health Legislation, regional office of Europe, WHO, Copenhagen
31. WHO,1993: Third Monitoring of Progress, Common Framework, CFM3, Implementation of Strategies for Health for All by the Year 2000, WHO, Geneva,
32. World Bank, 1993: *World Development Report 1993: Investing in Health*, Oxford University Press, New York

Two

Fundamental Right to Health and Public Health Care

Adv. Mihir Desai and Adv. Dipti Chand

Introduction

This Chapter deals with the following questions:

- Does the Indian Constitution recognize the fundamental right to health and health care?
- What are the contours of the right to health care?
- Is the State obliged to provide health care facilities to all citizens?
- Does this obligation extend to providing free, cheap or subsidized medical care?
- What are the obligations of the private health care sector?

The Indian Constitution and Right to Health

The Fundamental Rights and Article 21 (Right to Life with Dignity) forms the basis of Right to Health. Article 21 of the Indian Constitution, a fundamental right reads: "No person shall be deprived of his life or personal liberty except through procedure established by law." Till the 1970s the courts, by and large, had interpreted 'life' literally i.e. right to exist- right not to be killed. In late 1970s, the Supreme Court began to give an expanded meaning to the term 'life' appearing in Article 21. Over the years it has come to be accepted that life does not only mean animal existence but the life of a dignified human being with all its concomitant attributes. This would include a healthy environment and effective health care facilities. Today, therefore, the Fundamental Right to Life is seen in a broad context.

Fundamental Rights are enforceable by and large only against the State. The Chapter of Fundamental Rights prescribes the duty and the obligations of the State vis- a- vis the citizens. Thus when one is talking about right to health and health care as a fundamental right we are speaking of the State's obligation and not the obligation of private players- either individual practitioners or private hospitals or nursing homes. This does not mean that private players do not have an obligation to their patients or can behave in a negligent manner. But these players have no obligation to have a ceiling on their professional charges and so no obligation to provide free, subsidized or even cheap treatment. There are certain exceptions to this principle that will be discussed later on in this volume. It is in this context that privatization of health care needs to be viewed.

The 'Right to Health' is inseparable from 'Right to Life', and the 'Right to Medical Facilities' as a concomitant of 'Right to Health' is also part and parcel of Right to Life. In a welfare state, the corresponding duty to the right to health and medical facility lies with the State.

Part 3 of the Constitution prescribes the Fundamental Rights of the citizens. These rights are enforceable against the State in a Court of law. This Chapter does not anywhere categorically state that the right to health or healthcare is a fundamental right. However, it does prescribe right to life as a fundamental right. It is an expanded meaning given to this term that has allowed the Courts to prescribe that right to health and health care is a fundamental right.

Part 4 of the Constitution lists the Directive Principles of State Policy. These are the principles

which should be followed by the State as the guiding principles while enacting laws and policies but have traditionally been believed not to be enforceable in courts of law. A citizen cannot go to court for enforcing a claim which is purely based on Directive Principles. The importance of these principles, however lies in the fact that in interpreting Fundamental Rights the Courts can use the Directive Principles so as to interpret these rights as much in consonance with the Directive Principles as is possible. The obligation of the State to provide health care facilities is set out in the 'Directive Principles of State Policy'. The relevant provisions of the Directive Principles which cast a duty on State to ensure good health for its citizens are:

Article 38. State to secure a social order for the promotion of welfare of people-

State shall strive to promote the welfare of people by securing and protecting as effectively as it may a social order in which justice, social, economic and political, shall inform all the institutions of the national life.

State shall, in particular, strive to minimize the inequalities in income, and endeavour to eliminate inequalities in status, facilities and opportunities, not only amongst individuals but also amongst groups of people residing in different areas or engaged in different vocations.

In other words, no person will be deprived of a healthy life because he cannot afford it. The State must provide facilities that an economically better off person can afford out of his own pocket.

Article 39. Certain principles of policy to be followed by State- The State shall, in particular, direct its policy towards securing-

e) that health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength; and
f) That children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment.

Article 47. Duty of State to raise the level of nutrition and the standard of living and to improve public health-

The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medical purposes of intoxicating drinks and of drugs which are injurious to health.

Context of Judicial Intervention and Evolving Understanding of Right to Health

To begin with, the right to health as a fundamental right grew as an offshoot of environmental litigation initiated by environmental activists regarding the environment issues. Undoubtedly the right to environment was crucial because a polluted environment affects public health. A pollution free environment as a fundamental right presupposes right to health as a fundamental right. Logically, the explicit recognition of the fundamental right to health should have preceded the fundamental right to good environment. However, the development of jurisprudence in this branch has been the reverse. The right to unpolluted environment was recognized as a right in the first instance and from that followed the right to public health, health and health care.

Secondly, the right to health care has also been debated by the courts in the context of rights of Government employees to receive health care. A number of observations of the Court concerning the importance of these rights are to be found in cases dealing with denial or restriction of health care facilities for Government employees, and not to the general masses. This is the context of judicial pronouncements on health care.

The following case law will help in the following ways:

- To understand the affirmation of right to health and health care as a fundamental right.

- It will give us the growing understanding of different aspects of right to health.
- It provides tools for those who want to use them in similar situations.

While dealing with the issue of fundamental right to health and health care the courts have also dealt with specific categories such as under trials, convicts and mentally ill persons. The courts have recognized that imprisonment does not deprive a person of right to health and health care.

Case Law

Right to Health and Health Care

Public Health is State's Priority: In one of the earliest instances of public interest litigations - **Municipal Council, Ratlam vs. Vardhichand & Ors**,[1] the municipal corporation was prosecuted by some citizens for not clearing up the garbage. The corporation took up the plea that it did not have money. While rejecting the plea, the Supreme Court through Justice Krishna Iyer observed: "The State will realize that Article 47 makes it a paramount principle of governance that steps are taken for the improvement of public health as amongst its primary duties."

Right to Health is a Fundamental Right: In 1991, in **CESC Ltd. vs. Subash Chandra Bose,** (AIR 1992 SC 573,585) the Supreme Court relied on international instruments and concluded that right to health is a fundamental right. It went further and observed that health is not merely absence of sickness:

"The term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness but also ensure stable manpower for economic development. Facilities of health and medical care generate devotion and dedication to give the workers' best, physically as well as mentally, in productivity. It enables the worker to enjoy the fruit of his labour, to keep him physically fit and mentally alert for leading a successful economic, social and cultural life. The medical facilities are, therefore, part of social security and like gilt edged security, it would yield immediate return in the increased production or at any rate reduce absenteeism on grounds of sickness, etc. Health is thus a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. In the light of Arts. 22 to 25 of the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights and in the light of socio-economic justice assured in our Constitution, right to health is a fundamental human right to workmen. The maintenance of health is a most imperative constitutional goal whose realisation requires interaction by many social and economic factors."

People are entitled to adequate health care: **Mahendra Pratap Singh vs. Orissa State** [2]
The petitioner, an ex-sarpanch of Pachhikote Gram Panchayat approached the court for issuance of appropriate writ commanding the opposite parties to take effective measures to run Primary Health Centre at Pachhikote within Korei block in the district of Jaipur by providing all amenities and facilities for proper running of the said health centre. The Government of Orissa decided to open certain primary health centres in different areas in 1991-92 subject to fulfilment of certain conditions, on basis of demands of the local people and public at large.

The conditions fulfilled were as follows:

(i) The local people should provide minimum one acre of land duly pledged in favour of the Panchayat Samiti for the Medical Institution within a period of one month from the date of issue of this order.

(ii) The local people should provide permanent buildings for the medical institutions as well as for the staff within six months from the date of issue of this order."

The court noted:

Great achievements and accomplishments in life are possible if one is permitted to lead an acceptably healthy life. Health is life's grace and efforts are to

[1] 1980 Cri LJ 1075
[2] AIR 1997 Ori 37

be made to sustain the same. In a Country like ours, it may not be possible. To have sophisticated hospitals but definitely villagers of this Country within their limitations can aspire to have a Primary Health Centre. The Government is required to assist people, and its endeavour should be to see that the people get treatment and lead a healthy life. Healthy society is a collective gain and no Government should make any effort to smother it. Primary concern should be the PHC and technical fetters cannot be introduced as subterfuges to cause hindrances in the establishment of health centre.

The judgment stated that the gram panchayat was agreeable to offer of the gram panchayat building for running of the health centre. If the building was still available, the same could be utilised for the purpose of running of the PHC, till the new building was completed. The Government either diverts the staff from Korei or make suitable arrangement for running of the PHC in the building of Pachhikote Gram Panchayat. Necessary arrangement would be made within a period of three months from that day. This is perhaps the only judgement commending the right to health for a general population.

Health and Health Care of Workers is an essential component of right to life: In **CERC vs. Union of India,**[3] the Supreme Court was dealing with the rights of workers in asbestos manufacturing and health hazards related to it (See Chapter 8). The Court was dealing essentially with private employers involved in asbestos mining and industry. To begin with, the Court noted that the right to health and health care of a worker is a component of the fundamental right to life guaranteed under Article 21 of the Constitution of India. The Court observed:

Article 38(1) lays down the foundation for human rights and enjoins the State to promote the welfare of the people by securing and protecting, as effectively as it may, a social order in which justice, social, economic and political, shall inform all the institutions of the national life. Art. 46 directs the State to protect the poor from social injustice and all forms of exploitation. Article 39(e) charges that the policy of the State shall be to secure "the health and strength of the workers". Article 42 mandates that the States shall make provision, statutory or executive "to secure just and humane conditions of work". Article 43 directs that the Slate shall "endeavour to secure to all workers, by suitable legislation or economic organisation or any other way to ensure decent standard of life and full enjoyment of leisure and social and cultural opportunities to the workers". Article 48-A enjoins the Slate to protect and improve the environment. As human resources are valuable national assets for peace, industrial or material production, national wealth, progress, social stability, descent standard of life of worker is an input. Art. 25(2) of the UDHR ensures right to standard of adequate living for health and well being of the individual including medical care, sickness and disability, Article 2(b) of the International Convention on Economic, Social and Cultural Rights (ICESCR) protects the right of worker to enjoy just and favourable conditions of work ensuring safe and healthy working conditions.

The right to health to a worker is an integral facet of meaningful right to life to have not only a meaningful existence but also robust health and vigour without which worker would lead life of misery. Lack of health denudes his livelihood. Compelling economic necessity to work in an industry exposed to health hazards due to indigence to bread winning to him and his dependents should not beat the cost of the health. and vigour of the workman. Facilities and opportunities, as enjoined in Article 38, should be provided to protect the health of the workman. Provision for medical test and treatment invigorates the health of the worker for higher production or efficient service. Continued treatment, while in service or after retirement is a moral, legal and constitutional concomitant duty of the employer and the State. Therefore, it must be held that the right to health and medical care is a fundamental right under Article 21 read with Articles 39(c), 41 and 43 of the Constitution and make the life of the workman meaningful and purposeful with dignity of person. Right to life includes protection of the health and strength of the worker is a minimum requirement to enable a person to live with human dignity. The State, be it

[3] (1995) 3 SCC 42

Union or State Government or an industry, public or private, is enjoined to take all such action which will promote health, strength and vigour of the workman during the period of employment and leisure and health even after retirement as basic essentials to live the life with health and happiness. The health and strength of the worker is an integral facet of right to life. Denial thereof denudes the workman the finer facets of life violating Art. 21. The right to human dignity, development of personality, social protection, right to rest and leisure are fundamental human rights to a workman assured by the Charter of Human Rights, in the Preamble and Arts. 38 and 39 of the Constitution. Facilities for medical care and health against sickness ensures stable manpower for economic development and would generate devotion to duty and dedication to give the workers best physically as well as mentally in production of goods or services. Health of the worker enables him to enjoy the fruit of his labour, keeping him physically fit and mentally alert for leading a successful life, economically, socially and culturally. Medical facilities to protect the health of the workers arc, therefore, the fundamental and human rights to the workmen.

Therefore, we hold that right to health, medical aid to protect the health and vigour of a worker while in service or post retirement is a fundamental right under Article 21, read with Articles 39(e), 41, 43, 48A and all related to Articles and fundamental human rights to make the life of the workman meaningful and purposeful with dignity of person. The Court also held that the right is available not just against the State but also against private employers. The Court observed:

It would thus be clear that in an appropriate case, the Court would give appropriate directions to the employer, be it the State or its undertaking or private employer to make the right to life meaningful; to prevent pollution of work place; protection of the environment; protection of the health of the workman or to preserve free and unpolluted water for the safety and health of the people. The authorities or even private persons or industries are bound by the directions issued by this Court under Article 32 and Article 142 of the Constitution.

Right to Health Care of government employees is integral to right to life: In **State of Punjab vs. Mohinder Singh Chawla**[4], which dealt with right to medical treatment of Government employees, the Supreme Court observed:

It is now settled law that right to health is integral to right to life. Government has constitutional obligation to provide the health facilities. If the Government servant has suffered an ailment which requires treatment at a specialised approved hospital and on reference whereat the Government servant had undergone such treatment therein, it is but the duty of the State to bear the expenditure incurred by the Government servant. Expenditure, thus, incurred requires to be reimbursed by the State to the employee. The High Court was, therefore, right in giving direction to reimburse the expenses incurred towards room rent by the respondent during his stay in the hospital as an inpatient.

Environment Pollution is linked to Health and is violation of right to life with dignity: In **T. Ramakrishna Rao vs. Hyderabad Development Authority,**[5] the Andhra Pradesh High Court observed:

Protection of the environment is not only the duty of the citizens but also the obligation of the State and it's all other organs including the Courts. The enjoyment of life and its attainment and fulfilment guaranteed by Article 21 of the Constitution embraces the protection and preservation of nature's gift without which life cannot be enjoyed fruitfully. The slow poisoning of the atmosphere caused by the environmental pollution and spoliation should be regarded as amounting to violation of Article 21 of the Constitution of India.

It is therefore, as held by this Court speaking through P.A, Choudary, J., in **T. Damodar Rao and others vs. Special Officer, Municipal Corporation of Hyderabad**, AIR 1987 AP 171,

[4] 1997 2 SCC 83
[5] Writ Petition 36929/1998 T. Ramakrishna Rao vs. Hyderabad Urban Development Authority decided on 20.7.2001

the legitimate duty of the Courts as the enforcing organs of the constitutional objectives to forbid all actions of the State and the citizens from upsetting the ecological and environmental balance. In **Virender Gaur vs. State of Haryana**, 1995 (2) SCC 577, the Supreme Court held that environmental, ecological, air and water pollution, etc., should be regarded as amounting to violation of right to health guaranteed by Article 21 of the Constitution. It is right to state that hygienic environment is an integral facet of the right to healthy life and it would not be possible to live with human dignity without a humane and healthy environment. In **Consumer Education and Research Centre vs. Union of India**, (1995) 3 SCC 42, Kirloskar Brothers Ltd. vs. Employees' State Insurance Corporation, (1996) 2 SCC 682= AIR 1996 SC 3261, the Supreme Court held that right to health and medical care is a fundamental fight under Article 21 read with Article 39(e), 41 and 43, In **Subhash Kumar vs. State of Bihar**, AIR 1991 SC 420 = (1991) I SCC 598, the Supreme Court held that right to pollution-free water and air is an enforceable fundamental right guaranteed under Article 21. Similarly in Shantistar Builders v. Narayan Khimalal Totame, (1990) 2 SCJ 10 = AIR 1990 SC 630 = 1990 1 SCC 520, the Supreme Court opined that the right to decent environment is covered by the right guaranteed under Article 21. Further, in **M.C. Mehta vs. Union of India**, (1987) 4 SCC 463 = AIR 1988 SC 1037, Rural Litigation and Entitlement Kendra v. State of U.P., AIR 1987 SC 359, Subhash Kumar vs. State of Bihar (supra), the Supreme Court imposed a positive obligation upon the State to take steps for ensuring to the individual a better enjoyment of life and dignity and for elimination of water and air pollution. It is also relevant to notice as per the judgment of the Supreme Court in Vincent Panikurlangara vs. Union of India, AIR 1987 SC 990 - (1987) 2 SCC 165, **Unnikrishnan, JP vs. State of A.P.**, AIR 1993 SC 2178 - (1993) 1 SCC 645, the maintenance and improvement of public health is the duty of the State to fulfil its constitutional obligations cast on it under Article 21 of the Constitution.

Adequate and Quality medical care is part of Right to Health and Right to Life: The Allahabad High Court in **S.K. Garg vs. State of U.P.**[6] was dealing with conditions of public hospitals. The Petition had been filed raising concerns about the pitiable nature of services available in public hospitals in Allahabad. Complaints were made concerning inadequacy of blood banks, worn down X- ray equipment, unavailability of essential drugs and unhygienic conditions. The Court appointed a Committee to go into these aspects and report back to the Court. The High Court held:

"In our opinion, the allegations in the petition are serious. The Supreme Court in Consumer Education and Research Centre and others v. Union of India and others. 1995 (3) SCC 42 and in State of Punjab and others v. Mohinder Singh Chawla and others. 1997 (2) SCC 83 has held that the right to health is a part of the right to life guaranteed by Article 21 of the Constitution. It is indeed true that most of the Government Hospitals in Allahabad are in a very bad shape and need drastic improvement so that the Public is given proper medical treatment. Anyone who goes to the Government Hospitals in Allahabad will find distressing sanitary and hygienic conditions. The poor people, particularly, are not properly looked after and not given proper medical treatment. Consequently, most people who can afford it go to private nursing homes or private clinics. There are many complaints that the staff of the Government Hospitals are often in collusion with the Doctors who run private nursing homes. and deliberately do not look after the patients who come to Government Hospitals so that they may be driven to go to private nursing homes and they often advise patients to go to a particular nursing home. All this needs to be thoroughly investigated. This is a welfare State, and the people have a right to get proper medical treatment. In this connection, it may be mentioned that in U.S.A. and Canada there is a law that no hospital can refuse medical treatment of a person on the ground of his poverty

[6] In S.K.Garg vs. State of U.P. decided on 21.12.98

or inability to pay. In our opinion. Article 21 of the Constitution, as interpreted in a series of judgments of the Supreme Court, has the same legal effect." However, nothing has been reported on the follow up of this case and details are not available.

Can the State be compelled to start hospitals or primary health care centres?: No direct guidelines are available on this issue. But somewhat similar cases are cited below

In **Paschim Banga Khet Mazdoor Samiti vs. State of W.B.**[7] the Supreme Court though primarily dealing with the issue of obligation of the State to provide emergency health care to patients made a general observation of significance: "Providing adequate medical facilities is an essential part of the obligation undertaken by the State in a welfare state. The Government discharges this obligation by running hospitals and health centres. Article 21 imposes an obligation on the State to safeguard right to life of every person."

In the case of **Peoples' Union of Civil Liberties vs. Union of India**[8], public interest litigation was filed against the Government for backing out of a project to build a psychiatric hospital-cum-medical college in Delhi. The plan had been approved but when it was found that over Rs. 40 crores would be the expenditure, the Delhi Administration expressed its inability to fund such a project and the Central Government refused to take on its responsibility. The Supreme Court held that setting up of a psychiatric hospital in the capital city was necessary. Once land has been earmarked and on principle a decision taken that hospital should be shifted and part of it should be converted into a teaching institution while the other part should be a hospital, funding should not stand in way of locating such a hospital. As it was difficult to fund such a huge amount in a single year, it was to be taken up as a continuous project spread over a period. Hence, the Central Government and the Delhi Administration were directed to recommence and finish the project.

Compensation Claims against the State

Basis of Compensation by the State: Violation of Article 21 by the State will give rise to a claim under public law remedy.[9] The State is also vicariously liable for acts of its agents or police or Government hospitals. The earlier notion was that 'king could do no wrong' and the State could not be held liable for the wrongdoings of its servants. Thus, while public servants could be prosecuted or sued for damages for negligence or dereliction of duty it was not possible for the State to be sued likewise. In the last 20 years this aspect has undergone change. This aspect has also been dealt with in the Chapter 6 but the changed principle needs to be elaborated here because it flows partly from the fundamental right to health and health care.

Ordinarily, if a person suffers harm at the hands of a State representative acting in such a capacity, whether it is a doctor, a policeman or a bureaucrat, apart from criminally prosecuting such an individual the victim can file a suit for damages against such a person either in the civil court or in the Consumer Court. Such a case is expensive and lengthy. Many times the victim or her relatives are not even aware who caused the injury. Take the case of a person who dies in hospital because of the wrongful administration of an intravenous drug. The patient or her relatives may not know which doctor or nurse administered such a drug. Or take a case of an under trial being killed in police custody. The relatives may never know which of the many police officers were responsible for the death. In such a case criminal prosecution becomes difficult because it is always against marked individuals.

---

[7] (1996)4 SCC 37

[8] Decision of the Supreme Court given on 12/11/1991

[9] There are two kinds of civil remedies, viz., public law and private law remedy. Private law remedy involves action under torts or contract, whereas in the former, the claim is against the State for a wrong committed by it or persons acting under it. Both remedies exist independent of each other. For instance, in an incident of medical negligence by Government doctors, a cause of action may be instituted by invoking writ jurisdiction of SC or HC under Articles 32 & 226, respectively. Simultaneously aggrieved person will also be entitled to pursue civil law remedy in torts or contract against individuals before either Consumer courts or civil courts. (refer chapter 6)

In private establishments there has been a notion of vicarious liability, namely, the master is liable for the wrongdoings of his servants and so even if criminal prosecution may not be successfully launched, once negligence is proved, the hospital would still be liable to pay damages irrespective of whether the actual culprits are identified or not.

In the State sector however, the law was different. While identified individuals could be prosecuted or sued for damages, the State itself or its instrumentality, for instance a hospital could not be sued in torts for the negligence or wrongdoing of its agents or servants. This was on the age-old premise that 'king could do no wrong' and thus the State is not liable for the torts of its servants.

Developments in the Last Two Decades

This doctrine has undergone major change in the last 20 years in two ways. First, the Supreme Court held that if there was a breach of fundamental rights then the high courts and Supreme Court were empowered to order the State to compensate the victim not in the realm of private law payment of damages for breach of civil rights but in the public law realm of payment of compensation for violation of fundamental rights. Thus, whether the State was or was not liable in torts for actions of its servants it would be still liable if such actions amounted to violation of fundamental rights. Once it was held that right to health and health care is a fundamental right then a breach of such a right by a state functionary would also make the State liable for payment of compensation.

Subsequently, of course the Courts have also held that the doctrine that State is not liable for the torts of its servants is no more applicable in the present times and the State is also liable in torts.

The cases cited below illustrate that medical negligence was considered a violation of individual's right to health.

In **State of Tripura vs. Amrita Bala Sen,**[10] the Division Bench of Gauhati High Court was concerned with a case where two persons who were admitted to a Government hospital for cataract operation lost an eye each due to the operation. A Writ Petition was filed directly in the high court by these two persons claiming compensation from the State. The Division Bench found that the facts were quite clear and negligence of the doctors was apparent on the face of the record. The Court therefore directed the State to pay to each of these persons compensation of Rs. 60,000/- with interest. The State argued that the concerned individuals should be asked to file a civil suit in local courts (which would have been time consuming and also expensive) rather than approaching the High Court directly. But the Court rejected this contention and held that when the facts were clear, there was no need for the high court in cases of state negligence to ask the complainants to go through long-winded legal proceedings and could itself direct compensation.

In **Marri Yadamma vs. State of Andhra Pradesh**[11] the deceased was an under trial who died of 'congestive cardiac failure'. The Court held that under trials have the right to adequate medical care. The petition was filed by his spouse alleging negligence on part of the jail authorities and jail doctor in not providing appropriate treatment on time or referring to a specialist to determine the root cause of the ailment.

The deceased was in the jail for a span of nearly six months during which he complained of abdominal pain, giddiness, vomiting etc. No effort was made to diagnose the cause of the deceased condition. On 25/1/1995 he complained of acute abdominal pain and was admitted from in the jail hospital. On 29/1/1995 he was shifted to a Government hospital where he breathed his last on 30/1/1995. The post-mortem report showed that left and right lungs were congested and pleural cavities were normal, the heart was massively thickened and the aortic valves were fibrosed, aoratic opening was dilated and the stomach was found empty. The cause of death was noted as being due to congestive cardiac failure associated with aortic valve disease.

The High Court observed that the condition of the deceased at the time of his death was such that it

[10] 2005 1 GLR 7
[11] AIR 2002 AP 164

could have developed over a period of time and not immediately. Thus, it was abundantly clear that no care or caution was taken by the Respondents to get the deceased examined by a Surgeon or a specialist, even though he had often complained of various ailments. Further, the high court cast doubts over the genuineness of the medical record maintained by the jail hospital. If the cause of death of the deceased was congestive cardiac failure associated with aortic valve, then the deceased must have complained about some form of heart ailment one or two months prior to his death. As the jail authorities had suppressed original records this fact remained in question.

The high court stated that on arrest a prisoner merely loses his right to free movement. All other rights, including the right to medical treatment remains intact and it cannot be violated. The jail authorities had infringed a fundamental right of the deceased therefore the State was liable to compensate his widow as a public law remedy for an amount of Rs.2 lakh.

In **Noorunissa Begum vs. District Collector, Khammam**[12] the Petitioner's husband died in jail due to negligence on the part of the jail authorities in providing timely medical care and attention. On an inquiry it was found that few days prior to the death, he had complained of chest pain and on the fatal day when he collapsed there was a delay of nearly four hours to arrange for an escort to take him to a government hospital. There was no hospital or medical facility within the jail premises.

The jail authorities defended allegations of negligence in discharge of their duty on the ground that under Andhra Pradesh Prisoners (Attendance in Court) Rules, 1977, no prisoner could be taken out of prison without armed police escort, and that the delay in shifting the deceased to the hospital was due to delay in arranging armed police force escort.

The high court reiterated the law laid down by Supreme Court in Parmanand Katara case wherein it was stated that no state action or provision of law can intervene in ensuring timely treatment to a person in need of medical care, and held the jail authorities negligent and the State liable to pay Rs.1,50,000 as compensation to the Petitioner.

Further, the high court also directed the State to consider the proposal to include Rule 10-A in Andhra Pradesh Prisoners (Attendance in Court) Rules, 1977 that had been pending before it, and decide upon it within a time frame.[13] Rule 10-A read as:

Escort for persons confined in a prison requiring treatment in a hospital outside the prison, and from such hospital to the prison, shall be undertaken by the police. If such a prisoner is admitted as in-patient in any hospital, his custody during the period of such confinement shall be undertaken by the police.

Rights of Government Employees to Receive Health Care

The following case law refer to the issues and policies of reimbursement of medical expenditure either during service or after retirement from service and uphold the fact that adequate medical care is an employee's right to live with dignity.

In the **State of Punjab vs. Mohinder Singh Chawla,**[14] the Respondent was suffering from a heart ailment, which required replacement of two heart valves. Since the facility for such treatment was not available in the State hospital, the State Medical Board granted permission for treatment in AIIMS, New Delhi. Later the Respondent approached concerned authorities for reimbursement of medical expenditure. The Appellants rejected the claim on expenditure on

---

[12] AP HC dt. 27/6/2001

[13] As a rule, power of judiciary cannot stretch into the arena of legislature. It cannot direct Parliament or state legislature to pass enactment, however, in the instant case High Court acted to the contrary. The fact that the proposal of Inspector-General of Prisons and Director of Correctional Services, Hyderabad was already in existence to insert Rule 10-A, gave legitimacy to the directions of High Court. In the absence of the same and in consideration of the limitation of judicial review, it is unlikely High Court would have passed such an order.

[14] (1997) 2 SCC 83

room rent paid to the hospital because of a change in the State policy for employees and ex-employees that excluded expenses incurred on diet, stay of attendant and stay of patient in hotel/hospital. Thus, the issue before SC was the extent of State's responsibility to provide medical facilities to its employees. The State justified its policy on the ground that the ancillary expenses saddled it with needless heavy burden that limited its capacity to provide treatment for general patients.

The Supreme Court held that the rent of room for an in-patient is an integral part of the expenses incurred on medical treatment, and could not therefore, be excluded. Though the Court agreed that greater allocation was required to be made for general patients, it was the State's constitutional obligation to bear the expenses for the government servant while in service or after retirement.

Surjeet Singh vs. State of Punjab[15]. In circumstances where the state-run hospitals lacked expertise to treat a specific ailment, the Respondent State's health policy ruled that its employees and ex-employees could receive medical treatment in non-Government hospitals so specified in the policy that would be reimbursed. However, such employees and ex-employees were required to make a prior application to a Board constituted to decide whether the treatment was available in the Respondent State hospitals. Such advance notice applied even to emergency cases.

The instant appeal arose out of the refusal to reimburse expenditure incurred abroad at the rate of one of the hospital identified under the State Health Policy for open heart surgery. The Appellant's case was that on a personal visit abroad, he suddenly fell ill and had to undergo open heart surgery at a very short notice, and so, could not comply with the clauses under the State Health Policy on requisite intimation.

The Supreme Court held that the Appellant had the right to take steps in self-preservation. He did not have to stand in a queue before the Medical Board. The State could not insist that its employees should be treated only at a recognized Government institution when the state policy permitted treatment in private hospitals so earmarked. Therefore, a government employee could claim reimbursement at such rates as are applicable to the identified private hospitals.

In **Devindar Singh Shergil vs. State of Punjab**[16] dealt with a retired government employee. The Appellant, a retired government official, who had approached the Postgraduate Institute of medical Sciences (PGI), Chandigarh for kidney treatment, was declined admission as no accommodation was available. Due to malignant growth of kidney, the Appellant immediately left for UK and got himself treated. Later he filed his claim for reimbursement of the entire amount but the Medical Board sanctioned an amount that would have been incurred if the Appellant was treated at PGI, which equalled to Rs. 20,000.

The Supreme Court dealt with the issue "as to why the petitioner should not be reimbursed for medical expenses to the extent of the expenditure which may have been involved for his treatment/ operation if carried out in any of the recognized institutions/hospitals in India". Since the AIIMS was one such recognized hospital under the State Policy, the Supreme Court held that the Appellant was entitled to reimbursement at the AIIMS rate and further, as an admitted fact, if the Appellant would have been treated in India he would have been entitled to reimbursement of expenses on medical consumable, pharmaceutical items, therefore, he would also be entitled to reimbursement of such expenditure. The Respondent State was directed to pay Rs.22, 000 as per AIIMS rates for surgery and Rs.73, 000/- for expenditure incurred on medicines.

In **State of Punjab vs. Ram Lubhaya Bagga**[17] though the Supreme Court observed that the State had an obligation to provide health care facilities

---

[15] (1996) 2 SCC 336
[16] (1998) 8 SCC 552
[17] (1998) 4 SCC 117

to government employees and to citizens, the obligation was only to the extent of its financial resources for fulfilling the obligation.

The State Health Policy for its employees and ex-employees promulgated in 1991 provided for reimbursement of medical expenses incurred either in earmarked hospitals or at other hospitals, at the rate prevailing in such specified hospitals.[18] This policy imposed a heavy financial burden on the State and it issued a new policy under which there was no impediment or procedural hurdle in receiving treatment at any hospital but the reimbursement of medical expenses was to be restricted to such rates as fixed by the Director, Health and Family Welfare, Punjab for similar treatment or the actual expenditure, whichever was less. The instant petition was filed challenging this change in State policy.

The Appellants justified the change on the ground that under the earlier policy the bulk of the budget was spent on a few elites for such treatments like heart ailment etc. to the detriment of a large number of other employees as the State was not in a position to reimburse them out of the remaining funds. Hence, the facility of reimbursement of full charge at designated hospitals was withdrawn.

SC held that Court cannot question the propriety of a policy decision unless it is arbitrary and violates any constitutional rights. So far as the constitutional obligation of the State, it must provide for basic infrastructure for maintaining and improving public health. The State renders this obligation by opening Government hospitals and health centres, but in order to make it meaningful, it has to be within the reach of its people, as far as possible, to reduce the queue of waiting lists, and it has to provide all facilities for which an employee looks for at another hospital. At the same time no State has unlimited resources to spend on any of its project. That is why it approves its projects to the extent it is feasible. The same holds good for providing medical facilities to its citizens including its employees. The provision of facilities cannot be unlimited. It has to be to the extent finances permit. Article 41 of the Constitution also acknowledges the limited means of the State to serve the public and states that the State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want. Hence, the principle of fixation or rate and scale under the new policy was justified and could not be held as infringing 'right to life'.

K.P. Singh vs. Union of India[19] was a case filed by retired government employees against the procedural difficulties in the Central Government Health Scheme (CGHS) for pensioners to receiving timely treatment and reimbursement of expenditure incurred on such treatment. The Petitioners grievances were:

For the purpose of reimbursement of claims relating to medicine that were outside the CGHS formulary, CGHS beneficiaries other than retired government employees and freedom fighters could procure such medicines directly from a registered chemist and claim reimbursement on the strength of a filled-in pro forma of the service head of their respective ministry, department or office. While in case of retired beneficiaries under the Scheme, such medicines had to be indented by the CGHS dispensary concerned. The indentation process was tedious and time consuming and so, medicines could not be taken in time.

Secondly, a beneficiary of the Scheme would receive reimbursement only at a rate approved by the CGHS however, such rates were not updated from time to time. Further, rates of CGHS did not consider that in some towns or cities, like that of the petitioner, there were no government hospitals therefore, retired employees had no option but to receive treatment at private hospitals that were expensive causing a heavy burden on their meagre pockets.

---

[18] In Surjeet Singh case, Appellant was reimbursed at the rates of AIIMS even though he was treated abroad; or in Devindar Singh Shergil case, where the Appellant was reimbursed at the rate prevailing at AIIMS even though there were other hospitals specified in State Health policy that were cheaper than AIIMS

[19] (2001) 10 SCC 167

SC directed Respondents to issue circulars to the effect that in case of emergency, medicines that are outside the CGHS formulary could be obtained immediately from the local chemist concerned on the basis of an authority slip from the CMO in-charge of the CGHS dispensary. However, the Supreme Court refused to grant any relief vis-à-vis the rate of reimbursement as it was not within its power to dictate policy to State, though it may direct the State to review its rates and issue appropriate directions.

In **Kamlesh Sharma vs. Municipal Corporation of Delhi**,[20] the case was filed against the order of the Respondent by which it rejected the Petitioner's claim for reimbursement of expenditure incurred on medication for her husband. The Petitioner's husband was earlier a Government servant and covered by the State Health Policy and was being treated at one of the hospitals earmarked under the said policy. During the course of the treatment certain medicines were urgently required which were out of stock and therefore, were purchased by the Petitioner from outside. Petitioner was not reimbursed for the medicines purchased from outside. Respondent justified the impugned order on the ground that it was government policy to provide medicine to its pensioners but not to reimburse for purchases made from outside. The office order on which Respondents relied read as:

All medicines etc. including diagnostics facilities as is required for treatment of patients (pensioners and their families) will be provided free of charge at the Hospitals /Dispensaries. However, in no case reimbursement of expenditure incurred by a pensioner on treatment will be made.

The policy of the Respondent to the extent it refused reimbursement was challenged as being unreasonable and arbitrary, and liable to be struck down as unconstitutional. The high court held the policy to the extent it refuses reimbursement as unconstitutional. However, it also clarified that its order should not be understood as whittling down the right of the Respondents to frame or formulate a policy including one providing restriction or ceiling on reimbursement of expenses as long as the said policy is not violates Articles 14 and 21.

In other words, the courts cannot adjudicate on the propriety of government policy unless it is discriminatory or violates right to life. The judiciary cannot step into the shoe of Government and issue policies. The court will refuse to entertain matters that are solely filed on the basis that a more beneficial policy could have been issued.

Cases on Rights against various State Authorities

The case law cited below refer to the different executive wings of the Government such as the railways, the police, and to the entitlement to medical and health care to those who are within their jurisdiction or custody. Ram Datt Sharma's case and Dr. Sarosh Mehta's case are excellent examples of judicial activism where detailed directions effectively amounting to law making were given.

In **Ram Datt Sharma's case,**[21] the Rajasthan High Court dealt with responsibility of the railways in providing health care facilities to its passengers. The complaint was that neither in the trains nor on the platforms was adequate medical facilities provided and this caused tremendous hardship to commuters, especially on long distance trains. The court held that the right to health care was a fundamental right of all citizens, including passengers, and made the following directions:

(i) Instructions shall be issued by Railway Board to Zonal Railway to keep reserve a Coupe' of four births in long distance train that shall carry sign board 'MEDICAL FACILITIES' with symbol of Red Cross. Visible symbol of Red-cross shall also be displayed out side the compartment. Team of one Medical Officer, one made nurse and one attendant shall board train and travel in it after a distance of 500 Kms. or as directed by the Railway Board the team already travelled shall be replaced by

[20] Delhi High Court judgment dated 3/10/2002
[21] AIR 2005 RAJ 317

another team. The Coupe' shall be equipped with Oxygen Cylinder, life saving drugs and injections.

(ii) In every compartment of train, it shall be prominently notified that Medical Compartment is attached with the train to provide medical assistance to the passengers free of cost by a competent doctor and complaint book is available with the Train-GUARD.

(iii) Due publicity that Medical facilities are available to the passengers in all the long distance trains, shall be given on all the Platforms. This information shall also be displayed on national Television and broadcast on All India Radio. People of Country shall also be made aware through the news papers.

(iv) Chemist facilities shall be provided on the station premises keeping in mind the quantum of passenger's traffic.

(v) The Union of India and Railway Board shall ensure compliance of this order within sixty days from today.

Similarly, in **Dr. Sarosh Mehta vs. General Manager, Central Railways**[22] the issue was the liability of Suburban Railways in Mumbai in providing health care facilities for travellers, especially in view of frequency of accidents. Some very important directions were issued:

(i) The Railways shall notify an emergency telephone number and shall publicize the same in all compartments, stations and other places. The calls made to the said number shall be monitored by a special cell situated in the control room which shall be open for 24 hours. The personnel of such cell shall immediately contact nearest Station Master/s at the place of the accident. Such cell shall maintain records of the calls received as well as follow up reports.

(ii) Free parking for an ambulance outside all stations to be provided by Railways and the State Government wherever parking is available.

(iii) The ambulance/taxi should be called by the Station Master or his representative.

(iv) Sanction of funds for (a) Hammals/Porters and (b) Ambulance/taxi for transporting the victim from the accident spot to the hospital and if shifting of victim to the other hospital as required.

(v) Immediate shifting of accident victim to nearest hospital (Private or Government).The list of the ambulance services and the hospital submitted by Mr. J.P. Cama, learned counsel for the petitioner, shall be made available to all the Station Masters.

(vi) Minimum Two lightweight folding or collapsible stretches in all Stations and they are to be cleaned after every use. One rechargeable torch on every station, disposable sterilized hand gloves and first aid box at each station.

(vii) Printed format of Memo of reporting accident by Station Master to the Government Railway Police.

(viii) Walkie Talkie in all trains in Central Railway until Train Management System is introduced.

(ix) A Committee consisting of Divisional Medical Officers of each Railway, Dean of Municipal Hospital and Additional Commissioner of Police should monitor that the guidelines are being followed. One doctor nominated by Association of Medical Consultants be also included in the Committee. Committee will also hear the complaints. The Committee should submit its six monthly report to the General Manager of each Railways. The Committee should meet at least once in two months. All concerned persons would be at liberty to file or lodge complaints before the Committee for preventive measures and those complaints shall be looked into by the Committee as expeditiously as possible.

As regards plan of action for Station Masters and Government Railway Police, the court issued the following directions.

(i) Helpline number to be displayed in all coaches and all stations.

(ii) On receipt of information about accident, the following action:

---

[22] Writ Petition No. 2405 of 2001 in the Bombay High Court. Order passed on various dates but the main order is dated 6th October, 2004

(a) If an accident takes place in between the Stations, information to be sent to the Control Room about the accident;
(b) After locating of the accident site, the Control Room should inform to the concerned Station Master and he should make announcement for hammal/porters, GRP and call ambulance/ taxi;
(c) As soon as the announcement is heard, hammals and GRP should rush to the Station Manager's Office, taking the stretcher from the office, go to the accident site by the fastest mode available i.e. by train or by walking to reach the accident site at the earliest.
(d) After lifting the victim, the victim is to be brought by train or through the passing train/ ambulance/taxi to the Station.
(e) Meanwhile, the ambulance/taxi will be kept ready at the Station so that the victim is immediately shifted to the nearest hospital, whether private or government.
(f) Simultaneously care will be taken to stop the bleeding by the trained person of railway/GRP.
(g) All the possible efforts will be made to inform the relatives of victim about the accident immediately by GRP/Station Master.
(h) The complete data of the accident be made available in the control room.
(i) The available data of the accident will be kept before the coordinating Committee to take necessary steps to suggest measures for the improvement and better dealing with the accidents.
(j) Every accident victim should be shifted immediately.
(k) If the name of the victim is known, then the name should be announced on the public announcement system.

Subsequently, on February 8, 2006, the High Court passed the following order:
We perused the Affidavit of Dr. (Mrs.) Mohua Halder, Sr. Divisional Medical Officer, Mumbai Central, Western Railway and the Affidavit of Mr. Arvind Malkhede, Senior Divisional Commercial Manager of the Central Railway Administration in Mumbai. None of these two Affidavits answers and provides for solution regarding treatment to the accident victims in the nearest private hospitals. In the Affidavit filed by Arvind Malkhede, it is stated that all injured persons in railway accidents are given free treatment in Railway Hospitals, but so far as other hospitals are concerned, Railway's liability is restricted to free transportation of the injured persons to the hospital. It is the obligation and the responsibility of the Railways to take the accident victims to the nearest hospital. If the Railways or Government or Municipal hospital is not close by, the accident victims need immediate medical aid and attention at the nearby hospitals.

It appears from both the Affidavits that the injured persons as a result of untoward incident or other mishaps are transported from the site of the accident to the nearest State Government/ Municipality hospital at the cost of the Railways. However, it is a fact that many of the Government/ Municipality hospitals are at quite a distance from the Railway Stations and transporting the victim to nearest State Government/Municipality hospital many a time is proved fatal. Obviously, it is the obligation of the Railway authorities (Western Railway, as well as, Central Railway) that accident victims are provided treatment in the cases of emergency in the nearest private hospitals where the Government hospital/Municipality hospital is not within the 5 kilometer radius of the site of the accident. Having given thoughtful consideration to these aspects, we issue the following further direction:

The emergency treatment to the injured person/s, as a result of untoward incident or other mishaps in Railway premises shall be provided at the cost of Railway authorities in the private hospitals if nearest State Government/Municipality hospitals is/are in within 5 kilometers of the Railway premises where such incident or mishap had occurred.

In **Directorate of Enforcement vs. Ashok Kumar Jain,**[23] the Court held that the police are as much under a statutory obligation to preserve the life of persons under its custody by ensuring medical care and treatment, and taking into account the condition of their health. However,

[23] (1998) 2 SCC 105

the right of such persons cannot be used as shield to hinder police investigation.

In the instant Appeal, documents were recovered from the possession of the Respondent that showed there was a gross violation of the Foreign Exchange Regulation Act (FERA). The Respondent sought anticipatory bail to avoid interrogation on the ground that he suffered from a serious heart condition and produced medical records to support his plea. The high court passed a conditional order stating that "in case the Directorate considers custodial interrogation of the Respondent necessary, it should approach the Director, AIIMS to constitute a Board of cardiologists to examine the Respondent, and if the said Board forms an opinion that custodial interrogation is not feasible in that event it will be open to the officials to interrogate him under the care of doctors at AIIMS."

The Appellant challenged the condition imposed upon it by the high court. The Supreme Court held that the high court was wrong in imposing conditions on the Directorate regarding the manner in which interrogation of the Respondent was to be modulated.

No doubt investigating officials of the Enforcement Directorate are duty-bound to bear in mind that Respondent has put forth a case of delicate health condition. They cannot overlook it and they have to safeguard his health while he is in their custody. But to say that interrogation should be subject to the opinion of the cardiologists of the AIIMS and that the officials of the Directorate should approach the Director of AIIMS to constitute a Board of Cardiologists to examine the Respondent etc. would, in our opinion, considerably impair the efficient functioning of the investigating authorities under FERA. The authorities should have freedom to chalk out such measures as are necessary to protect the health of the person who would be subjected to interrogatory process. They cannot be nailed to fixed modalities stipulated by court for conducting interrogations.

D.K. Basu vs. State of West Bengal[24] is a landmark case on the rights of arrestees. The Supreme Court prescribed a number of guidelines to be mandatorily followed by arrested persons. Two of these directions pertained to health. The Court observed:
The arrestee should, where he so requests, be also examine at the time of its arrests and major and minor injuries, if any present on his/her body, nust be recorded at that time. The "Inpection memo" must be signed both by the arrestee and teh police officer effecting the arrest and its copy provided to the arrestee.

The arrestee should be subjected to medical examination by a trained doctor every 48 hours during his detention in custody by a doctor on the panel of approved doctors appointed by Director, Health services of the concerned State or Union territory, Director, Health Services shall prepare such a panel for all Tehsils and Districts as well.

Obligations of Private Sector

With increasing privatization of the health care sector and gradual withdrawal of the State from it, it becomes important to understand what are the rights of citizens vis a vis the private sector. The various obligations of private sector are discussed in detail in the following chapters of this book.

A crucial issue arose both in Bombay and Delhi concerning the obligation of the private sector to provide free and subsidized treatment to a certain quota of patients. The overwhelming majority of large hospitals and some of the Nursing Homes are registered as public trusts. Such registration entitles them to income tax exemption as well as certain other benefits. These hospitals have traditionally been given certain other relaxations including duty exemptions while importing drugs and medical equipment as also certain building construction relaxations such as additional floor space index, cheap land, etc. It is well known that these hospitals charge exorbitant fees and charges and are virtually unaffordable even to large sections of the middle class. But if these hospitals are registered as charities, get tax exemption, get subsidized land from the government and get various other relaxations, should they not be

[24] AIR 1997 SC 610

obliged to render at least some amount of cheap and subsidized services?

The Public Trusts Acts which operate in Delhi and Bombay, as also in many other places provide that if the State has given certain amount of aid to 'charitable' hospitals these hospitals are liable to treat certain quota of patients totally free and certain other quota of patients on a subsidized basis. Aid could be in various forms- direct financial assistance, tax exemption, import duty exemption, lands given at cheap rate, etc. It was found that most of the hospitals were not complying with the requirements and were evading them under one pretext or the other. Public litigations were filed in both the Bombay and the Delhi High Courts. Delhi High Court appointed a retired High Court judge- Justice Qureshi to enquire into the issue and report back to the High Court. He filed a comprehensive and detailed report before the Delhi High Court and the case is pending. In Bombay High Court a similar exercise was carried out and the Court passed a detailed order by which a scheme was prepared in order to ensure that private hospitals provide free and subsidized treatment to certain number of poor patients. The Scheme passed by the Bombay High Court is quite instructive and is being reproduced here in full at the end of the chapter.*

Conclusion

The Fundamental right to health and health care has been recognized by the Supreme Court. Though this is a major leap there are number of limitations.

First, fundamental rights are available only against the State and not against private individuals or organizations.

Second, the State is required to enforce this fundamental right which is, however, subject to financial availability.

But the positive outcomes have not been that citizens have been using the fundamental right to get better facilities from State hospitals, cast obligations on State doctors and on custodial institutions. Prisoners and mentally ill have been held to be equally endowed with this right. The growth of environmental litigation in India is premised on the recognition of the right to health as a fundamental right.

Even so, various questions remain unanswered. If a poor person has the fundamental right to health and health care can she approach the Court and demand that he/she should be given free treatment at a Government hospital? To what extent can such a free treatment be demanded? Can it be said that the free treatment extends to providing expensive drugs and procedures free of charge? Can it include complex surgeries? Since the right to health care has been recognized as a fundamental right the answers to all these questions should be in the affirmative. But looking at the manner in which the Courts have been acting in recent times they are likely to say that yes, it is a fundamental right, but subject to the financial capacity of the State. These are the areas in which in the next few years the Court battles are likely to be fought, all the more so because the State has been withdrawing from the health sector.

A negative fundamental right casts an obligation on the State not to act in a manner that would deprive a citizen of her fundamental right. On the other hand, a positive fundamental right would mandate the State to take proactive measures to fulfil its obligation. Time has come for the Courts to recognize that the right to health and health care is a positive fundamental right that cannot be contingent upon the financial capacity of the State. Meanwhile, the people's movements and communities have now begun struggles to stop the State from privatizing and thus unregulated commercialization of the health care which further violates the right to the health of the citizens. The activists in the health field will have to use both these strategies –– to urge the state to provide health care to all citizens and also to stop the state from unleashing commercialization and privatization of health care on the other. Using the Right to Life as the broader framework, the Court rulings would be useful tools for all those who join hands to pursue a vision 'Health for All, Now'.

*CHARITABLE HOSPITALS JUDGEMENT

The Scheme for treatment to indigent patients and weaker section patients for the purposes of section 41AA of the Bombay Public Trusts Act, 1950, approved by Bombay High Court is as follows:

1. The public Charitable Trust registered under the provisions of the Bombay Public Trusts Act, 1950 (for short 'BPT Act') which are running Charitable Hospital, including nursing home or maternity home, dispensaries or any other centre for medical relief and whose annual expenditure exceeds Rs.5 lakh are 'state-aided public trust' within the meaning of clause 4 of section 41AA.
2. The public Charitable Trust covered by aforesaid clause 1 shall be under legal obligation to reserve and earmark 10 per cent of the total number of operational beds for indigent patients and provide medical treatment to the indigent patients free of cost and reserve and earmark 10% of the total number of operational beds at concessional rate to the weaker section patients as per the provisions of section 41AA of the BPT Act.
3. In an emergency, the Charitable Hospitals must admit the patient immediately and provide to the patient 'Essential Medical Facilities' for all life saving emergency treatment and procedure till stabilization. Further transportation to the public hospital would be arranged by such Charitable Hospital, if necessary. The Charitable Hospitals shall not ask for any deposit in case of admission of emergency patients.
4. That each public Charitable Hospital shall create separate fund which may be called Indigent Patients' Fund (for the sake of brevity, hereinafter referred to as "IPF") and shall credit two per cent of gross billing of all patients (other than indigent and weaker section patients) without any deduction.
5. Donations that may be received by the Charitable Hospitals from individuals or other charitable trusts or from any other source for providing medical treatment to the indigent and weaker section patients shall be credited to IPF Account.
6. The account of IPF shall have to be earmarked under the head of IPF and same shall be reflected under the earmarked fund in the annual balance sheet (Schedule VIII Rules 7(1) of the B.P.T. Rules).
7. The amount credited to the IPF Account shall remain at the disposal of the respective Charitable Hospital and that amount shall be utilized only for providing medical treatment to the indigent and weaker section patients as provided herein after.
8. The Charitable Hospitals shall provide following non billable services free to the indigent patients as well as weaker section patients—
   (a) Bed
   (b) RMO Services
   (c) Nursing Care
   (d) Food (if provided by the hospital)
   (e) Linen
   (f) Water
   (g) Electricity and
   (h) Routine Diagnostics as required for treatment of general specialties.
   (i) House Keeping services.
9. In case of indigent patients, the Charitable Hospitals shall provide medical examination and treatment in its each department totally free of cost. The indigent patient's bill of billable services shall be prepared at the rates applicable to the lowest class of the respective hospital. The medicines, consumables and implants are to be charged at the purchase price to the hospital. If doctors forego their charges, then the same shall not be included in the final bill of the indigent patients. The bill so prepared shall be debited to IPF Account. The Charitable Hospitals shall not ask for any deposit in case of admission of indigent patients.
10. In case of weaker section patients, the Charitable Hospitals shall provide medical examination and treatment in its each department at concessional rates. The weaker section patient's bill of billable services shall be prepared at the rates applicable to the lowest class of the respective hospital. The medicines, consumables and implants are to be charged at the purchase price to the hospital; however,

the weaker section patients shall pay at least 50% of the bills of medicines, consumables and implants. If doctors forego their charges, then the same shall not be included in the final bill of the weaker section patients. The bill so prepared after deducting the payment made by the weaker section patients shall be debited to IPF Account.

11. The Charitable Hospitals shall physically transfer 2% of the total patients' billing (excluding the bill of indigent and weaker section patients) in each month to IPF Account. The amount available in the IPF Account shall be spent to provide medical treatment to maximum number of indigent and weaker section patients. In case of surplus or shortfall in the IPF Account of the month, the same shall get adjusted in the subsequent months. In case there is imbalance in the credit of the IPF Account and the expenditure incurred in the treatment of indigent and weaker section patients for more than six months, such a Charitable Hospital may bring this aspect to the notice of the Monitoring Committee who may issue appropriate directives to the concerned hospital.
12. The Charitable Hospitals shall furnish information to the office of the Charity Commissioner regarding the amount collected in the IPF Account, treatment provided to the indigent patients and the weaker section patients and their profiles prepared by the Medical Social Worker and the amount spent for the respective patients along with the information required to be sent under Rule 25A of the Bombay Public Trusts Rules, 1951.
13. The Trustees of the charitable hospitals shall not provide medical facilities to their relatives, the employees of the Trust and their dependants in the category of "indigent and weaker section patients".
14. The Charitable Hospitals shall admit indigent or weaker section patients coming to their hospitals from any source or through Government Hospitals, Municipal Hospitals, etc. The procedure for admission of patients shall be as provided in subsequent clauses.
15. The Charitable Hospitals shall admit indigent patients to the extent of 10% of their operational beds/average occupancy for medical examination and treatment. So also, the Charitable Hospitals shall admit weaker section patients to the extent of 10% of their operational beds/average occupancy for medical examination and treatment coming to their hospitals from the sources referred to in clause 14. The Charitable Hospitals shall verify the economic status of the patients from their Medical Social Worker on the basis of scrutiny of any one of the following documents produced by the concerned patients:
(i) Certificate from Tahsildar; (ii) Ration Card/ Below Poverty Line Card.
16. The Members of the Monitoring Committee in Greater Mumbai Region shall be as follows:-
    (i) Joint Charity Commissioner, Maharashtra State, Mumbai (Chairman).
    (ii) Joint Director of Health Services (Medical), Mumbai (Member-Secretary).
    (iii) Secretary/Nominee of Association of Hospitals in Mumbai (Member).
    (iv) Health Officer, Municipal Corporation of Greater Mumbai, Mumbai (Member).
    The Monitoring Committee at the District Level shall be as follows:-
    (i) Joint Charity Commissioner (Regional Level) or his nominee (Chairman).
    (ii) Civil Surgeon (Member-Secretary).
    (iii) Health Officer of Zilla Parishad (Member).
    (iv) Representative of Charitable Hospitals in Districts (Member).
17. The Monitoring Committee shall hold its meeting once in a month and monitor implementation of the Scheme by each of the Charitable Hospitals. The Monitoring Committee shall also consider grievances of the patients, if any, made and submit its report to the Charity Commissioner.
18. In case of the breach of the Scheme and/or the terms and conditions of section 41AA by any Charitable Hospitals, besides the penal action as is provided under Section 66 of the B.P.T. Act, the Charity Commissioner shall make report to the State Government recommending withdrawal of the exemption granted to the concerned hospitals during the

next preceding year in payment of contribution towards P.T.A. Fund and the amount of contribution towards P.T.A. Fund be recovered from the said hospital. The Charity Commissioner may also request the Government to withdraw any other concessions/benefits given to the said hospital.

19. The Charitable Hospitals which face individual difficulties in meeting objectives/ obligations under this Scheme shall be at liberty to apply to the Charity Commissioner with all supporting documents who may consider suitable modifications, if a case for relief is made out.
20. The Charity Commissioner shall notify the list of the Charitable Hospitals in Greater Mumbai Region on the Notice Board of his office and two newspapers widely circulated in Greater Mumbai, one in Marathi and the other in English and the list of Charitable Hospitals in each District on the Notice Board of the office of the Joint Charity Commissioner and the two widely circulated newspapers of the District.
21. Each of the Charitable Hospitals governed by this Scheme shall publish the Scheme on its Notice Board displayed at a conspicuous place of the Hospital.

We clarify that the following two points have been left open to be reconsidered after one year of the implementation of the Scheme by the charitable hospitals, viz., (one) the expenses incurred on indigent/weaker section patients to be billed against IPF at lowest rate charged by Charitable hospitals to the lowest class of patients and (two) the restoration of the concessions, relief's and the benefits which have been withdrawn.

We record our appreciation for the work done by the Expert Committee headed by the Charity Commissioner in submitting the draft Scheme under section 41AA of the B.P.T. Act for our consideration, after taking into consideration all relative aspects, including the views of the Association of Hospitals. We would like the public Charitable hospitals to remind themselves, the human service for which they came into existence, each time they provide treatment and health service to the indigent and weaker section patients.

The Scheme shall come into operation with effect from 1st September 2006.

The Charity Commissioner is directed to submit the report indicating the implementation of the Scheme by each charitable hospital for the period from 1st September 2006 to 31st August 2007 and the action against such hospitals, which defaulted in full implementation of the Scheme. The report shall be submitted by 30th September, 2007.

Let the matter come up 'for directions' on 4th October, 2007. Sd R M LODHA

Three

Right to Emergency Health Care

Adv. Mihir Desai and Adv. Dipti Chand

Introduction

The following questions repeatedly confront doctors, patients and social and legal activists:

- Are doctors and hospitals bound to attend to emergency patients?
- Is the obligation same for government hospitals and private hospitals?
- If it is a police case, should the police formalities be first completed before attending to a patient?
- What if the patient or her relatives do not have money to bear expenses for the treatment?

We read about and hear of many cases where emergency patients are sent from one hospital to another without receiving proper attention. Often private hospitals refuse to admit medico legal emergency cases (like accidents, poisoning and attempted suicide, etc.) and ask them to approach public hospitals.

In India, there is no law that deals specifically with the duties of health facilities and personnel to provide medical treatment in emergency cases. Emergency health care, like public health facilities falls in the shadow of Article 21. In other words, where there is a refusal to treat an emergency case, the patient may approach the court to claim compensation for violation of his/her right to life. The Supreme Court has held that the failure to provide timely medical care amounts to violation of the fundamental right to life.

The state has an obligation to provide medical facilities in such circumstances, and financial inability or lack of infrastructure is no justification to avoid this obligation. Whenever the state fails to discharge its constitutional obligation, the patient or immediate kin may approach either the Supreme Court or the High court under Articles 32 or 226[1] of the Constitution, as a legal remedy. Court may also be approached by a public-spirited person or organization as the Supreme Court, in a number of judgments has held that the traditional concept of 'locus standi' does not strictly apply to such cases.[2] The Supreme Court and the High courts also have the power to convert a letter concerning any issue of public importance into a Public Interest Litigation (PIL) suo moto (at its own initiative).

In the ordinary course of practice private medical practitioners and private hospitals, have a right to decide whether to undertake a case or not.[3] However, the Supreme Court, while deciding upon delay in treatment of medico-legal cases by

---

[1] Art 32 is the right to move the Supreme Court by appropriate proceedings for the enforcement of the rights and Art 226 is the power of the courts to issue any person or authority, including in appropriate cases, any government, within those territories directions, orders on a case bought before them.

[2] One of the basic principles of law is that only such a person can approach the court that is directly affected by the chain of events which gives rise to the legal proceedings. Thus, at the admission stage the aggrieved party must establish its *locus standi*. If such a party fails then the matter is held not maintainable, i.e., the court has the jurisdiction to try the matter but will not do so because the party claiming relief does not have the right to claim such relief.

[3] "When a patient consults a doctor, the doctor owes him certain duty, viz., a duty of care in deciding whether to undertake the case and a duty of care in deciding what treatment to give. A breach of any of these duties gives a right of action for negligence to the patient." **Dr. Laxman Balkrishna Joshi vs. Dr. Trimbak Bapu Godbole** AIR 1969 SC 128

government hospitals, has held that neither government nor even private hospitals can refuse treatment in a medico-legal emergency. But, if a private hospital refuses treatment then which forum is to be approached? Article 21 of the Constitution dealing with the right to life is normally not available against private parties. Consumer courts and civil courts deal with **tortuous liability**[4] of doctor or hospital i.e. negligence in treatment. If the hospital refuses to treat a patient in emergency cases this can definitely amount to negligence in the performance of its duty towards the patient, and a consumer court or civil courts can be approached.

However, in Chapter 2 of the Code of Medical Ethics Regulations 2002 drawn up by the Medical Council of India with the approval of the central government it has been said:

> **2.1 Obligations to the sick:**
> Though a physician is not bound to treat each and every one asking his services except in emergencies for the sake of humanity and the noble traditions of the profession, he should not only be ever ready to respond to the calls of the sick and the injured, but should be mindful of the high character of his mission and the responsibility he incurs in the discharge of his ministrations, he should never forget that the health and the lives of those entrusted to his care depend on his skill and attention. A physician should endeavour to add to the comfort of the sick by making his visits at the hour indicated to the patients.
>
> **2.4 The patient must not be neglected:**
> A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant. No provisionally or fully registered medical practitioner shall wilfully commit an act of negligence that may deprive his patient or patients from necessary medical care.

Of course, there will continue to be a number of grey areas. For instance, if a patient suffers a heart attack in the clinic of a general practitioner, to what extent is the general practitioner liable to treat such a patient. It appears that in such a case the general practitioner would be required to give ordinary care and treatment to a patient but will not be expected to extend the kind of treatment that a heart specialist would be expected to provide. Or while travelling in an aircraft if a passenger suffers a stroke, is a doctor co passenger obliged to treat traveller so taken ill? There is still no clarity on these areas. In the absence of a specific law, there is also not likely to be clarity in every area since the law develops depending on the cases which come up before the court and such development is very erratic and uneven.

Case Law

Obligation to Provide Emergency Health Care

In **Paschim Banga Khet Mazdoor Samiti vs. State of W.B.**[5] the issue before the Supreme Court was the legal obligation of the Government to provide facilities in government hospitals for treatment of persons who had sustained serious injuries and required immediate medical attention. The petitioner who had suffered brain haemorrhage in a fall from the train was denied treatment at various government hospitals because of non-availability of beds.

The patient was given first aid in a PHC and referred to a specialized state hospital for better treatment.

---

[4] Tortuous liability arises from the breach of a duty primarily fixed by law. In the case of doctors it is negligence in treatment

[5] (1996)4 SCC 37

At the specialized hospital, the patient was examined and X-rays of his skull were taken which showed his condition to be serious. Immediate admission for further treatment was recommended. However, he was not admitted in that hospital as there were no vacant beds, and was referred to another specialized hospital. There too, he was refused admission as there were no vacant beds. After doing the rounds of three more state-run specialized hospitals, the patient was admitted to a private hospital and the final bill came to much more than he could afford. He had to spend Rs. 17,000 for his treatment.

The West Bengal government justified its action on the ground that the petitioner could not have been kept on the floor of a hospital or trolley because such an arrangement of treatment was fraught with grave risks of cross-infection, and moreover there was a lack of facility for proper care after the operation. The government of West Bengal further stated that state hospitals catered to the need of poor and indigent patients, and 90 per cent of the beds maintained by the state government all over the state, were designated as free beds for treatment of such patients.

During the hearing of the case, the state government appointed an enquiry committee to investigate the matter. It concluded:

Even in excess of the sanctioned beds some patients are kept on the trolley-beds in the morning and that even if it is dangerous to keep a patient with head injuries on a trolley-bed he could very well be kept for the time being on the floor and could be transferred to the cold ward, as the situation demanded, temporarily. In the instant case, the Emergency Medical Officer (EMO)concerned should have taken some measure to admit the petitioner and he is, therefore, responsible for non-admission in the said hospital. In a situation of this kind, the Superintendent of the hospital should take some measures to give guidelines to the respective medical officers so that a patient is not refused admission when his condition is grave...

The EMO should have contacted the superior authority over the telephone if there was any stringency as to the beds available and admit the patient in spite of the total sanctioned beds not having been available. The Superintendent should have given guidelines to respective medical Officers for admitting serious cases under any circumstances and thus in a way the Superintendent was responsible for this general administration.

Various recommendations made by the Enquiry Committee were adopted by the state government and the following directions were issued by the West Bengal State Government to health centres/OPD/ Emergency Departments of hospitals in dealing with patients:

1. Proper medical aid within the scope of the equipments and facilities available at the Health Centres and hospitals should be provided to such patients and proper records of the treatment given should be maintained and preserved. The guiding principle should be to ensure that no emergency case is denied medical care. All possibilities should be explored to accommodate emergency patients in serious condition.
   To avoid confusion Admission/Emergency Attendance Registers shall contain a clear recording of the following information:
   a) name, age, sex, address, disease of the patient by the attending MO;
   b) date and time of attendance/examination/ admission of the patient; and
   c) whether and where the patient has been admitted, transferred, referred;
   Further, there should be periodical inspection of the arrangement by the Superintendent and responsibility fixed for maintenance and safe custody of the registers.
2. Emergency Medical Officers will get in touch with Superintendent/Deputy Superintendent/ Specialist Medical Officer for taking beds on loan from cold wards for accommodating such patients as extra-temporary measures.
3. Superintendents of hospitals will issue regulatory guidelines for admitting such patients on internal adjustments amongst various wards and different kinds of beds including cold beds and will hold regular weekly meetings for monitoring and reviewing the situation.
4. If feasible, such patients should be accommodated in trolley-beds and, even, on the

floor when it is absolutely necessary during the exercise towards internal adjustments as referred to above.

The Enquiry Committee made certain other suggestions which were also accepted by the state government:

- A central Bed Bureau should be set up which should be equipped with wireless or other communication facilities to find out where a particular emergency patient can be accommodated when a particular hospital finds itself absolutely helpless to admit a patient because of physical limitations. In such cases the hospital concerned should contact immediately the Central Bed Bureau which will communicate with other hospitals and decide in which hospital an emergency serious patient is to be admitted.
- Some casualty hospitals or trauma units should be set up at some points on regional basis.
- The intermediate group of hospitals, viz., the district, sub-division and the State general hospitals should be upgraded so that a patient in a serious condition may get treatment locally.

Apart from directions of the government of West Bengal and the recommendations of the Enquiry Committee, the Supreme Court made some additional recommendations:

1. Adequate facilities should be available at the PHCs where the patient can be given basic treatment and his condition stabilized.
2. Hospitals at the district and sub-divisional level should be upgraded so that serious cases can be treated there.
3. Facilities for giving specialist treatment are to be increased and having regard to the growing need, it must be made available at the district and sub-divisional level hospitals.
4. In order to ensure availability of bed in an emergency at state level hospitals, there should be a centralized communication system so that the patient can be sent immediately to the hospital where bed is available in respect of the treatment which is required.
5. Proper arrangement of ambulance should be made for transport of a patient from the primary health centre to the district hospital or sub-divisional hospital to the state hospital.
6. Ambulance should be adequately provided with the necessary equipment and medical personnel.

The Supreme Court observed that while financial resources would be required for the implementation of the above directions, the constitutional obligation of State to provide adequate medical services to the people cannot be ignored. The Court also observed:

"In the context of the constitutional obligation to provide free legal aid to a poor accused this Court has held that the State cannot avoid its constitutional obligation in that regard on account of financial constraints. (Khatri II vs. State Of Bihar). These observations will apply with equal, if not greater, force in the matter of discharge of constitutional obligation of the State to provide medical aid to preserve human life. In the matter of allocation of funds for medical services the said constitutional obligation of the State has to be kept in view."

The Court held that it was necessary that a time-bound plan for providing these services should be chalked out keeping in view the recommendations of the Committee as well as the requirements for ensuring availability of proper medical services in this regard as indicated by us and steps should be taken to implement the same. The Court also observed:

Providing adequate medical facilities is an essential part of the obligation undertaken by the State in a welfare state. The Government discharges this obligation by running hospitals and health centres. Article 21 imposes an obligation on the State to safeguard right to life of every person. Preservation of human life is thus of paramount importance. Government hospitals run by the state and the medical officers employed therein are duty-bound to extend medical assistance for preserving human life. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21' (para 9)

This case arose out of an incident in West Bengal. Other states were not parties to the case. Also, the Committee was concerned with West Bengal and the directions were also given by the West Bengal

Government. However, the Supreme Court observed that other states, though not parties, should also take necessary steps in the light of the recommendations made by the Committee, the directions contained in the Memorandum of the Government of West Bengal dated August 22, 1995 and the further directions given in the Judgment. Thus all the directions referred to above, would be equally applicable to other states in the country. Besides, the Union of India was a party to these proceedings. The Court observed that since it was the joint obligation of the Centre as well as the States to provide medical services it is expected that the Union of India would render the necessary assistance in the improvement of the medical services in the country on these lines. The Court also ordered that the Petitioner be paid Rs. 25,000 as compensation.

Implementation of Case Law

Labonya Moyee Chandra vs. State of West Bengal[6] case reflected the lack of seriousness of the State in executing its duties and the implementation of the directions and recommendations in Paschim Banga Khet Mazdoor Samiti case.[7]

The patient was an old woman residing in a village near the city of Burdwan who was denied admission in SSKM, a state hospital on account of non-availability of bed even though her condition was recorded as critical. This hospital was also involved in the earlier case of Paschim Banga Khet Mazdoor Samiti.

The patient suffered severe chest pain and difficulty in breathing. The local doctor examined her, diagnosed a heart block and recommended immediate hospitalization. She was taken to Burdwan where she was shown to Burdwan Medical College hospital (BMCH) who referred her to cardiology department of Seth Sukhlal Karnanl Medical College (SSKM) in Calcutta or any other State hospital having cardiology department as they didn't have the said facility. At SSKM, RMO referred her to the cardiology department who informed her that there were no vacant beds and referred her back to the RMO. She instead got admitted to a private hospital were she underwent an operation and a permanent pacemaker was implanted.

There were two issues before the Supreme Court: First, whether the patient was brought to SSKM hospital in a critical state, and second, whether she was refused admission and 'turned out at night'.

The Supreme Court considered the following evidence to conclude that the patient indeed was in a critical state, based on the case notes and prescription of the local doctor, the discharge certificate of the BMCH and the endorsement of the cardiology RMO on the outdoor emergency department ticket of the SSKM hospital:

1) The prescription of the local doctor recorded that patient was unconscious, suffering from convulsion and frothing at the mouth. He diagnosed a complete heart block condition known as *Stokes-adams*. It is a medical term to designate occasional transient cessation of the pulse and loss of consciousness, especially caused by heart block. *'The condition of such patient must be critical.'* Accordingly the local doctor advised urgent hospitalization, and prescribed oxygen inhalation and medication.
2) Discharge certificate of BMCH described her condition as a 'complete heart block' and referred her to a State hospital with a cardiology department.
3) The endorsement of the cardiology RMO on the outdoor emergency department ticket of SSKM hospital also described her as suffering from a 'complete heart block' with S.A. Attack. This clearly showed that Appellant's condition was not stable as alleged by the State.

As regards the second issue, the Supreme Court held that though the SSKM hospital did not turn her out, she could not possibly have been expected to bear with the jostling between the two departments when she was in a critical state. It was the responsibility of the doctor in charge of the cardiology department who examined her, to ensure that a bed was made available in any of the department so that she could be accommodated in

[6] SC decided on 31/7/1998
[7] ibid

the cardiology department as and when a vacancy arose.

The Supreme Court observed that despite the directions issued by it and the State government in Paschim Banga Khet Mazdoor Samiti case[8] there had been no compliance of the same. The Appellant was denied treatment in BMCH on grounds of lack of proper facility. This was despite the specific direction in Mazdoor Samiti case to upgrade facilities and to set up specialist treatment in the district-level hospitals. "Clearly State Government has not taken any follow up action to ensure that recommendations are implemented." There was no 'centralised communication system' set up with the help of which BMCH could have referred the Appellant to a hospital that had vacant beds before setting her off on a long journey in a critical state. The 'admission register' maintained by SSKM hospital was not as per the guidelines set out in the Mazdoor Samiti case. The entries were haphazardly and irresponsibly made. They did not describe the medical condition of the Appellant although such a column had been provided. The inquiry report submitted by SSKM hospital to the Court did not show that a bed could not be arranged for the Appellant. It was silent about the occupancy of beds in other departments.

In the light of above circumstances and lapses on the part of State and the government hospital to implement the recommendations in Paschim Banga Khet Mazdoor Samiti case[9], the Supreme Court held the state liable to compensate the Appellant for the cost of the pacemaker assessed at Rs.25, 000. Further, the State government was directed to take follow up action on the implementation of the recommendations under the earlier case.

Medico Legal Cases

Right to Emergency Care during Accidents:

Parmanand Katara vs. Union of India[10] was a petition filed by a human rights activist seeking directions against the Union of India that every injured citizen brought for treatment should be instantaneously given medical aid to preserve life and thereafter the procedural criminal law should be allowed to operate in order to avoid negligent death. The Petition also demanded that in the event of breach of such direction, apart from any action that may be taken for negligence, appropriate compensation should be admissible. The Petitioner had appended to the writ petition a report titled 'Law helps the injured to die' published by the *Hindustan Times* that told the story of a hit-n-run case where the victim was denied treatment by the nearest hospital and asked to approach another hospital authorized to handle medico-legal cases but situated 20 km away. The victim succumbed to his injury on the way to the other hospital. There were three issues before Supreme Court:

1. Whether there are any legal impediments that hindered timely treatment in medico-legal cases;
2. What is the nature of the duty of the government, the government hospital and the police in medico-legal cases; and
3. Whether private hospitals could refuse to treat medico-legal cases?

The Medical Council of India in its affidavit stated that though doctors are not bound to treat every case they cannot refuse an emergency case on humanitarian grounds and the noble tradition of the profession necessitates this. The affidavit stated that the doctors were reluctant to undertake medico-legal cases because of unnecessary harassment by the police during the course of investigation and trial. The MCI urged that doctors attending medico-legal cases should be indemnified under the law from any action by the government/ police authorities so that it is conducive for doctors to perform their duties. Criminal procedure should be amended so that injured persons may be treated immediately without waiting for a police report or completion of police formalities. The Indian Evidence Act should also be amended so that the diary maintained by doctors in the regular course of their work is admissible as evidence for the purposes of the medico-legal cases in place of their presence during trial to prove the same.

---

[8] ibid
[9] ibid
[10] AIR 1989 SC 2039

A report of the Committee headed by the Director General of Health Services was filed. It had taken the following decisions:

1. Whenever any *medico-legal* case attends the hospital, the medical officer on duty should inform the Duty Constable, name, age, sex of the patient and place and time of occurrence of the incident, and should start the required treatment of the patient. It will be the duty of the Constable on duty to inform the concerned Police Station or higher police functionaries for further action. Full medical report should be prepared and given to the Police, as soon as examination and treatment of the patient is over. The treatment of the patient would not wait for the arrival of the Police or completing the legal formalities.
2. Zonalisation as has been worked out for the hospitals to deal with medico-legal cases will only apply to those cases brought by the Police. The *medico-legal* cases coming to hospital of their own (even if the incident has occurred in the zone of other hospital) will not be denied the treatment by the hospital where the case reports, nor the case will be referred to other hospital because the incident has occurred in the area which belongs to the zone of any other hospital. The same police formalities as given in para 1 above will be followed in these cases.

All Government Hospitals, Medical Institutes should be asked to provide the immediate medical aid to all the cases irrespective of the fact whether they are medico-legal cases *or otherwise*. The practice of certain Government institutions to refuse even the primary medical aid to the patient and referring them to other hospitals simply because they are *medico-legal cases is not desirable*. However, after providing the primary medical aid to the patient, patient can be referred to the hospital if the expertise facilities required for the treatment are not available in that Institution.

The Union government filed its affidavit and denied that there was any legal impediment in criminal procedural law to hinder treatment in emergency cases. The affidavit mentioned, " There are no provisions in the Indian Penal Code, Criminal Procedure Code, Motor Vehicles Act, etc. which prevent doctors from promptly attending seriously injured persons and accident case before the arrival of the Police and their taking into cognisance of such cases, preparation of F.I.R. and other formalities by the Police.

The Supreme Court, agreeing with this, held that-

There is no legal impediment for a medical professional when he is called upon or requested to attend to an injured person needing his medical assistance immediately. The effort to save the person should be the top priority not only of the medical professional but even of the police or any other citizen who happens to be connected with the matter or who happens to notice an incident or a situation.

Preservation of human life is of paramount importance. That is so on account of the fact that once life is lost, the status quo ante cannot be restored as resurrection is beyond the capacity of man. The patient whether he is innocent person or liable to be punished under the laws of the society, it is the obligation of those who are in charge of the health of the community to preserve life so that innocent may be protected and the guilty may be punished. Social laws do not contemplate death due to negligence to tantamount to legal punishment. A doctor at the Government hospital positioned to meet the State obligation is, therefore, duty bound to extend medical assistance for preserving life. **Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life.** No law or State action can intervene to avoid delay the discharge of the paramount obligation case upon the members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with discharge of this obligation cannot be sustained and must, therefore, give way.....Zonal regulations and classification

cannot operate as fetters in the process of discharge of the obligation and irrespective of the fact whether under instructions or rules, the victim has to be sent elsewhere or how the police shall be contacted, the guidelines indicated in the 1985 decision of the Committee on Forensic Medicine (set up by the Ministry of Home Affairs of the Government of India) are to become operative.

Significantly, in this case the Supreme Court observed that every doctor whether in a government establishment or a private individual had the duty to extend immediate medical treatment in consonance with his skills to save life.

Role of Police in Emergency Cases:

In **Supreme Court Legal Aid Committee vs. State of Bihar**[11] the Supreme Court held that the responsibility to provide immediate medical treatment to an injured person in a medico-legal case extends even to the police. Thus, where the deceased who was lynched by the mob for attempting to rob passengers of train, died because of negligence of the police in taking him to a hospital on time and also for the inhuman manner in which he was bound up and dumped in the vehicle, the Court held that this amounted to a violation of right to life and the State was bound to pay Rs.20, 000 as compensation for the loss of life. It is altogether another matter that the compensation awarded was a pittance.

Poonam Sharma vs. Union of India[12] is another case pertaining to the liability of police and government hospitals in medico-legal case, the Petitioner's husband met with an accident while driving in an allegedly drunken state. The police took him to a government hospital for a check up where the doctor on duty stitched up an inch long cut on his scalp and gave him Brufen tablets. Later the deceased was taken into custody and charged for drunken driving under the Motor Vehicles Act, 1988. In the night the deceased complained of severe headache and the police took him to the same doctor who again prescribed Brufen tablets. During the night the condition of the deceased deteriorated. The next day his family bailed him out and took him to another hospital where he succumbed to brain haemorrhage.

The high court observed that in a case of head injury, it is elementary knowledge that extra care is required to be taken. Such extra care is required to be taken, particularly in medico-legal cases. In medico-legal cases, the doctor as also the police authorities are under statutory obligation not only to see that injuries suffered by a person who has been brought to the hospital are properly taken care of but also, every doctor at the government hospital having regard to the paramount importance of preservation of human life is statutorily obliged to extend his services with due expertise.

The instant case was not of an error in clinical judgment. Within a few hours, the patient was brought back complaining of severe headache. Despite that no further treatment was given and he was asked only to take Brufen tablets. Thus, in light of the facts and circumstances of the case and that the deceased was only 30 years old drawing a salary of Rs.3,000 per month, the high court ordered Rs. 2 lakh as compensation to the Petitioner.

Conclusion

The courts have now been recognizing that the State and State-run medical institutions have the obligation to provide medical care in cases of emergency. This cannot be dependent upon adequate infrastructure, etc. In the **Paschim Banga Case**[13], the Court ordered central bed bureaus as also upgraded facilities in district and sub district hospitals to be set up. These have not been widely implemented. But groups working on health can definitely file Public Interest Litigations in high courts for implementation of these orders in their respective states.

Although the responsibility of the State and government hospitals is well provided by a radical interpretation of the Constitution, there is no

[11] (1991) 3 SCC 482
[12] AIR 2003 Delhi 50
[13] ibid

definite corresponding legal duty imposed on private hospitals and practitioners to treat emergency cases except for the observation which is excerpted above. The above judgments focus on the duty of State and government hospitals. In this regard, the Lawyer for the patient in Paschim Banga Khet Mazdoor Samiti case made a few interesting suggestions drawing from the legal position in the US. It was urged that the denial of treatment should be specifically made a cognizable offence and further, that it should also be made actionable as a tort.[14] In the US it was found that private hospitals were turning away uninsured, indigent person in need of urgent medical care and these patients were often transferred to, or dumped on public hospitals and the resulting delay or denial of treatment had sometimes disastrous consequences. To meet this situation US Congress has enacted the Consolidated Omnibus Budget Reconciliation Act, 1986 (for short COBRA) to prevent the practice of dumping of patients by private hospitals. By this Act all hospitals that receive medical care benefits and maintain emergency rooms are required to perform two tasks before they may transfer or discharge any individual: (i) The hospital must perform a medical screening examination of all prospective patients, regardless of their ability to pay; (ii) If the hospital determines that the patient suffers from an emergency condition, the law requires the hospital to stabilize his condition. It cannot transfer or discharge an unstabilized patient unless the transfer or discharge is appropriate as defined by the statute. COBRA also imposes a penalty on hospitals and physicians who negligently violate its provisions. In addition, the individual who suffers personal harm as a direct result of the refusal to treat has a right to pursue civil action against the defaulting hospital.

Indian courts have held that in emergencies neither government nor even private doctors can insist on payment of money before dealing with the patient. In **Pravat Kumar Mukerjee vs. Ruby General Hospital,**[15] the National Consumer Commission was concerned with the case of a young student whose motorcycle was dashed by a bus in Calcutta. He was brought to the Respondent hospital but the treatment was not continued as Rs.15, 000 as demanded by the hospital were not immediately paid. The boy died. The National Commission held that though a doctor was not bound to treat each and every patient, in emergencies the doctor was bound to treat the patient and could not insist on delaying treatment until the fees were paid. The Petitioner was awarded a compensation of Rs. 10 lakh.

In conclusion all doctors and hospitals, whether private or government, have to treat emergency patients. If they do not do so, the patient or immediate kin can approach the court for compensation for violating their right to life (Article 21). The excuse of having no beds does not hold in the case of government hospitals and detailed recommendations are given in this regard. The obligation is the same for government hospitals and private hospitals. The courts have clearly held that no legal procedures can take priority over providing life saving treatment for the patient. If such procedures are required by the law, then that law must be amended.

---

[14] In civil law, the liability of doctor arises when there is a duty of care, a breach of such duty and consequential injury. The duty is not absolute, which implies that a doctor need not treat all those who approach him. He has the right to refuse. He is liable for harm caused only to those whom he undertakes to treat.

[15] Original Petition No. 90 of 2002 decided by the National Commission on 25.4.2005

Four

HIV/AIDS and Law

Adv. Vijay Hiremath

Introduction

HIV/AIDS victims and activists in India are constantly grappling with the following legal questions:

- Can discrimination of patients in hospitals on the basis of their being HIV+ be challenged legally and compensated?
- Are there any safeguards legally for the patient's confidentiality?
- Can the patient's confidentiality be breached under any circumstances, legally?

Today in many countries across the world HIV/AIDS* is considered to be a disability and accordingly the person suffering with HIV/AIDS is given protection as a disabled person and is given protection from being ostracized and also helps person to secure a job as there is reservation for the disabled persons. In India, people suffering from HIV/AIDS are not included under the Disability Act of 1995.

'Directive Principles of State Policy' under the Constitution enumerate guiding principles for States to be followed while formulating their policies. These provide that it is the primary duty of State to improve public health,[1] and it should promote a social order in which justice, social, economic and political shall form part of all institutions of national life.[2]

The above provisions, in the context of AIDS, imply that a person suffering from AIDS cannot be condemned by denying him ways of or affording him opportunity to lead a normal life. It is the duty of State to provide for his treatment or treatment at affordable price, employment to ensure he does not die an economic death, rehabilitation et al. State must also direct its public health policy to prevent spread of AIDS/HIV.

The 'Directive Principles of State Policy' are mere guidelines and unenforceable in the court of law. However, the State can be compelled to execute its duties so far as it concerns public health because as set out in the earlier chapters various Supreme Court judgments have interpreted the expression 'life' under Article 21 to include right to health and all reasonable health facilities. Therefore disregard of public health is a violation of fundamental rights of people to life.

As is obvious, litigation concerning AIDS in India is of recent origin and still in an embryonic form. After the first few cases of HIV were detected in 1986 the government of India constituted the National Aids Committee in 1986 under the Ministry of Health and Family welfare and representatives from different sectors and similarly the State Aids Control Societies were formed in various states. At present the AIDS control programme of the government of India is under the National Aids Control Organization (NACO). The Government in India has always had a knee jerk reaction to such issues and that has lead to loss of liberty of individuals and also discrimination in the society. The Goa Public Health Act, 1987 is an example of the reaction of the governments and the discrimination that followed where AIDS

---

[1] Art. 47
[2] Art. 38

patients were sought to be stigmatized under the law and segregated.

In the recent past the courts in India have taken a more informed approach to the issue of HIV/AIDS and have passed orders which have helped in reducing discrimination. Right from stopping people being kept under captivity, to stopping discrimination on the basis of the disease and safeguarding the employment of the affected people and to the policy on drugs required for the HIV positive people, the courts have issued important judgements.

Case Law

This chapter covers a wide range of litigation in courts on the issue of HIV/AIDS with the main purpose of highlighting the apathy of the government and the discriminatory policies adopted and to point to the large amount of work that still needs to be done in this area.

Isolation

Lucy D' Souza vs. State of Goa[3] was one of the first litigations on the issue of HIV/AIDS in India. S. 53(1) (vii) of the Goa Public Health Act, 1987, empowered the government to isolate a person suffering with AIDS. The Act did not specify a particular period of isolation or where it should take place, but that isolation was acceptable for such person, and at such institution or ward as may be prescribed. Thus wide powers were given to the government to take away the liberty of the individual on grounds that a person was suffering from AIDS.

Apart from the violation of the rights guaranteed under the Constitution of India, the petition raised four basic issues regarding this provision:

1. Provision for isolation is based on wrong scientific material and foundation;
2. object sought to be achieved by isolation is nullified by the provision;
3. discretion to isolate is unguided and uncontrolled; and
4. the provision for isolation is procedurally unjust in the absence of the right of hearing

While dealing with the aspects (1) and (2) the court was of the opinion that, isolation was an invasion of the personal liberty of a person and it may also lead to ostracization. The court also held that a balance has to be drawn between the right of the individual and society at large. In a situation of conflict between the right of a private individual and the society at large the latter should prevail over the former.

It was also considered that the isolation might lead to people not coming forward and going underground if they are suffering from HIV/AIDS. Thus they will not be able to take proper treatment.

Regarding the contention that the discretion of isolation was unguided and uncontrolled, the court held that the government was within its powers to make provisions for controlling the spread of AIDS. It also stated that proper rules had been formulated by the government in this regard. In the matter of notice and hearing prior to the action of isolation the court held that there were many provisions and actions where compliance with this principle of natural justice not possible. The court was also of the opinion that the condition of prior hearing and notice would frustrate the provision of isolation. Such a hearing could be given after the isolation.

Blood Banks

In the case of **Common Cause vs. Union of India**[4] the Supreme Court laid down guidelines regarding operation of blood banks. The issue raised before the court was that the deficiencies and shortcomings in collection, storage and supply of blood through blood centres operating in the country could prove fatal.

Blood is one of the mediums through which HIV/AIDS is transmitted. Blood has become a commodity. Some people become professional donors as it is a source of earning for them. Blood banks play an important role at different stages of

[3] AIR 90 BOM 355
[4] AIR 1996 SC 929

medical treatment. Since the supply of wrong type or contaminated blood can cost lives of patients, the Court felt that it was essential to regulate the donation of blood and its quality. Under the Drugs and Cosmetics Act, 1940 blood is treated as a 'drug' for the purpose of regulating its collection, storage and supply.[5] The PIL was against the deficiencies and shortcomings in collection, storage and supply of blood through blood centres operating in the country. The Supreme Court issued the following directions concerning operation of blood banks.

- The Union Government shall take steps to establish forthwith a National Council of Blood Transfusion as a society registered under the Societies Registration Act.
- In consultation with the National Council, the State Government/Union Territory (UT) Administration shall establish State Councils, which shall be registered as a society under the Societies Registration Act, in all States/UTs.
- The National Council shall undertake training programmes for training of technical personnel in various fields connected with the operation of blood banks.
- The National Council shall take steps for starting special postgraduate courses in blood collection, processing, storage and transfusion and allies field in various medical colleges and institutions in the country.
- The Union Government, State Governments and UTs should ensure that within a period of not more than a year all blood banks cooperating in the country are duly licensed and if a blood bank is found ill-equipped for being licensed, and remains unlicensed after the expiry of the period of one year, its operations should be rendered impossible through suitable legal action.
- The Union Government, State Governments and UTs shall take steps to discourage the prevalent system of professional donors so that the system of professional donors is completely eliminated within a period of not more than two years.
- The existing machinery for the enforcement of the provisions of the Drugs and Cosmetics Act and Rules should be strengthen and suitable action be taken in that regard on the basis of the Scheme submitted by the Drugs Controller (I) to the Union Government for up-gradation of the Drugs Control Organization at the Centre and the States.
- Necessary steps should be taken to ensure that Drugs Inspectors duly trained in blood banking operations are posted in adequate numbers so as to ensure periodical checking of the operations of the blood banks through out the country.

The Union Government should consider the advisability of enacting a separate legislation for regulating the collection, processing, storage, distribution and transportation of blood and the operation of the blood banks in the country. This direction, of course has as yet not been carried out.

In India, the Epidemic Diseases Act, 1897 requires medical practitioners to notify the health officer of any person with infectious disease and disclose the identity of the individual. The Goa Public Health (Amendment) Act, too, by implication, allows for disclosure/notification to public officials of an individual's HIV status by giving them the power to test and isolate such persons they suspect of having the virus. The weighing of the social and personal consequences is not always an easy task. In most cases, the doctor has to assess the risk of infection to a third party caused by his patient's reluctance to disclose his HIV status. He has to balance his duty to warn the third party with that of confidentiality in regard to his patient.

The following case covers the issue of isolation and blood banks:

Public interest litigation was filed to espouse the cause of HIV infected persons after a 21- year-old mother and her daughter, were driven out of her house after her husband died of AIDS. On arrival at her parental home, her condition worsened and the whole family was ostracised. On being brought to the Guwahati Medical College Hospital, they were sent to the Infectious Diseases Hospital, and then to the Isolation Ward. Later on, when

[5] Blood banks are regulated under Drugs and Cosmetics Rules, 1945, Part X-B 'Requirements for the collection, storage, processing & distribution of whole human body, human blood components by blood banks & manufacture of blood products'

discharged, they had no place to go. The petition demanded that treatment of HIV positive persons without discrimination should be made available in all hospitals, the blood banks should not be permitted to operate without licence and control; and that counselling centres be set up on a priority basis. The Court issued the following directions [6]

(i) The guidelines and strategies formulated by the NACO shall be properly implemented in letter and spirit with due regard to the London Declaration of Aids Prevention of January 28, 1988 and the Global Strategy formulated by the WHO. (See Annexure 4)

(ii) The State authorities shall close those blood banks which are operating in the State without valid licence and establish a State Transfusion Council to regulate the affairs of the blood banks in the State ensuring that all tests mandatorily required to be done as prescribed by the WHO before transfusion of blood are carried out.

(iii) AIDS Counselling Centres should be opened at different State Hospitals throughout the State, depending upon necessity and steps should be taken for effective functioning of the AIDS Counselling Centre opened at Mahendra Mohan Choudhury Hospital, and trained and qualified persons shall be appointed for AIDS Management Programme to prevent spread of AIDS in State.

(iv) Appropriate steps should be taken immediately to provide adequate equipment and other facilities in the three medical colleges in Assam and trained persons should be posted to participate effectively in the AIDS Management Programme.

(v) Effective monitoring system should be evolved to supervise the implementation of the programme including a regular audit of accounts subject to the guidelines framed by the NACO in addition to regular audits by the Accountant General, Assam.

(vi) Appropriate orders/directives be issued to ensure that persons suspected to be suffering from AIDS or HIV positive shall not be refused treatment in the hospitals. On such matters coming to the notice, appropriate action should be taken against the erring doctors or the staff.

Employment

In **MX of Bombay Indian Inhabitant vs. M/s. ZY**[7] the issues raised concerned not only the right to employment of an HIV affected person but also the safety of other employees and the responsibility of the employer to provide medical treatment to its employees who are suffering from HIV/AIDS. The high court held that an HIV affected person could not be denied employment or be discontinued unless it was medically shown that he was suffering from such a disease that can be transmitted through daily chores. Taking into consideration the widespread and present threat of this disease in the world, in general, and this country in particular, the State cannot be permitted to condemn HIV-affected people to economic death. The court felt that it was not in public interest and was not permissible under the Constitution. The interest of the HIV affected persons, employers and society would have to be balanced in such a case, if it meant putting an economic burden on the State or public corporation or society, and they must bear the same in the larger public interest.

The person who approached the court was a casual labourer with the Respondent, a state corporation, and had been short listed for being absorbed into the latter's permanent workforce. In the pre-employment medical test, he was found to be HIV+ive and consequently, denied regularization.[8]

The state government's argument was that if a candidate was inflicted with a disease that was most likely to assume serious proportions in due course, the public body could not be saddled with the responsibility and liability of extending medical facility and treatment to such a candidate by recruiting him. In prescribing pre-employment medical test, the employer intended to recruit such

[6] Subodh Srama and Anr vs State of Assam decided on 26.09.2000
[7] AIR 1997 BOM 406
[8] A person already in employment cannot be terminated merely because he suffers from AIDS/HIV unless shown that it has incapacitated him to continue working and he poses a threat to the health of other employees. 'Termination of the services of a workman on ground of continued ill-health.' Section 2(oo) of Industrial Dispute Act, 1947

persons, who would be able to serve the full term of employment, i.e., till the age of superannuation.

The high court rejected the contention of the State government and held that the object of medical test prior to employment or during the course of employment, was to ensure that such a person was capable of or continues to be capable of performing his normal job requirements and that he did not pose a threat or health hazard to other persons or property at the workplace. Persons who were rendered incapable of performing their normal function or posed a risk to other persons at workplace— for instance, due to a contagious disease that could be transmitted through normal activities at the workplace— could be reasonably and justifiably denied employment or discontinued from employment. Such a classification has a clear nexus with the object to be achieved, viz., to ensure the capacity of such persons to perform normal job functions as also to safeguard the interest of other persons at the workplace.

AIDS is transmitted through sexual intercourse, blood transfusion or from mother to new-born child. HIV is not transmitted through insects, food, water, sneezing, coughing, toilets, human excreta, sweat, shared eating and drinking utensils or other items such as protective clothing or telephones. Thus an HIV person cannot be denied employment or be discontinued unless it can be medically shown that he suffered from a disease that could be transmitted through daily chores.

The high court further stated that the State and the public corporation could not take a ruthless and inhuman stand against employing a person unless they were satisfied that the person will remain in service during the entire span of employment upto superannuation. The most important thing in respect of persons infected with HIV is community support, economic support and non-discrimination. This is also necessary for prevention and control of this incurable condition. Taking into consideration the widespread and present threat of this disease in the world in general and this country in particular, the State cannot be permitted to condemn HIV persons to economic death. This is not in the public interest and is impermissible under the Constitution. The interest of the HIV persons, employers and society will have to be kept in balance in such a case that if it means putting an economic burden on the State or a public corporation or the society, they must bear the same in the larger public interest.

In this case, the Court also permitted an HIV-afflicted person to file a case without disclosing his identity due to the stigma attached.

In **M. Vijaya vs. The Chairman and Managing Director, Singareni Collieries Company Ltd.**[9] the Andhra Pradesh High Court held that it was the duty of the hospital to check whether the blood was infected or not, and the lack of proper equipment to detect the virus was not an excuse. The high court went beyond the point of medical negligence and laid down important guidelines for the effective implementation of the programmes to curb the spread of the virus and to deal with the people who have been tested positive of HIV.

The patient had a blood transfusion during an operation at the hospital run by the company. The patient's brother was the blood donor and the said hospital had conducted various tests including test for AIDS that was negative. After the operation the Petitioner's health deteriorated. Numerous tests were conducted on the Petitioner and she was found to be suffering from AIDS. To determine the source, the Petitioner's brother's blood was again tested for HIV after a gap of 10 months and the report was positive. In the instant petition it was alleged that the Respondent's hospital was negligent in conducting the test on her brother because of which HIV could not be detected. Respondent-company, on the other hand urged that during the window period or asymptomatic period, HIV/AIDS can go undetected, and it could unknowingly be transmitted to others. Therefore, they could not be held to be negligent.

The high court observed that based on the information provided by the Respondent-company that approximately 1,000 employees were suffering from AIDS/HIV and this number was bound to increase when their family members were included.

[9] 2002 ACJ 32

Adv. Vijay Hiremath
COMMUNITY HEALTH CELL LIBRARY AND INFORMATION CENTRE
RHR-130 10033

Under such circumstances, the high court held the Respondent-company to be negligent as they failed to disclose whether the doctors working in their hospital were themselves aware of the problem; if the pathologists working were technically competent to carry on the tests; and if both Elisa and/or Weston Blot tests were conducted on the blood donor.

The importance of this judgment is that in the light of the magnitude of the problem among the Respondent-company's employees, the nature of the disease and its social dimension, the high court shifted the burden on the Respondent-company to show that its hospital was well trained and equipped, both technically as well as with requisite expertise to prevent the spread of the same. Importance was also given to the attitude of the employer in cases of AIDS/HIV. The court expressed its disapproval at the apathy of the Respondent-company's hospital in neither carrying out requisite blood tests on the Petitioner after the operation, nor referring her to a super specialty hospital for test and treatment. The high court also noted that despite the knowledge that Petitioner was suffering from AIDS, the Respondent-company gave her no financial or other help.

The high court went beyond the issue of medical negligence to issue appropriate directions for the effective implementation of various AIDS control programmes taken up by the Government and the NGOs.[10] In summary while the hospital was not held to negligent for not picking up the diagnosis in the brother (as he may have been in the window period), it went on to lay down some very important observations and guidelines which can be followed up by NGOs and governments.

AIDS Control Measures

To begin with the high court took note of the AIDS control programmes of the Government. The Central Government established a National AIDS Control Organization (NACO) to ensure high level of awareness of HIV/AIDS and its prevention, to promote the use of condoms for safe sex in high risk population, i.e., migrant labours, truckers, prison inmates etc.

In Andhra Pradesh the Directorate of AIDS Control Programme was established in 1992 in close coordination and collaboration with other Government departments, public, private and NGOs. The Directorate was responsible for development and implementation of AIDS control plan as approved by NACO. As per the guidelines of NACO an AIDS Control Society was constituted for Andhra Pradesh in 1998 to pursue long-term and short-term objectives. The long-term objectives are:

a) Prevent the spread of HIV infection;
b) reduce the morbidity and morality associated with HIV infection,
c) the establishment of effective programme management at all levels;
d) the provision of technical and operational support; and
e) to mobilize community support to restrict transmission by conventional methods.

The short-term objectives are

a) strengthen Sexually Transmitted Disease (STD) clinics;
b) modern Blood Banks to facilitate HIV testing;
c) strengthening of HIV/AIDS surveillance and prevention activities;

---

[10] The judgment also has negative connotation when it states that "in an apparent conflict between the right to privacy of a person suspected of HIV not to submit himself forcibly for medical examination and the power and duty of the State to identify HIV infected persons for the purpose of stopping further transmission of the virus. In the interests of the general public, it is necessary for the State to identify HIV positive cases and any action taken in that regard cannot be termed as unconstitutional as under Article 47 of the Constitution, the State was under an obligation to take all steps for the improvement of public health. A law designed to achieve this object, will not be in breach of Article 21 of the Constitution of India." (p.513, para.52)

The above position of HC is an obiter dicta and has no precedent value. It should be noted that courts as a principle do not substitute their views for that of experts in a concerned field. There are statistic and observation of National and International bodies that forced exposure hasn't succeeded in preventing HIV/AIDS. The above observation is an outcome of ill-founded notions and that is why public education and awareness is important.

d) human resource development to manage HIV infected and AIDS patients;
e) to create awareness about HIV transmission and its control;
f) promote the safety of blood and blood products; and
g) organize social support to HIV/AIDS patients.

In Andhra Pradesh, there are 142 licensed blood banks of which 44 from Government sector, five Central Governments, two autonomous, 11 quasi Government, voluntary, 33 hospitals- attached and 38 are private commercial blood banks. NACO has upgraded the zonal blood banks and the district level blood banks by supplying equipment like blood blank refrigerators, centrifuges, water baths, etc. HIV and Hepatitis-C Elisa and Raid test kits are being supplied by NACO. All the medical officers, staff nurses and laboratory technicians working in Government Blood Banks are supposed to be trained in HIV testing techniques and blood banking technology. Further, the State Blood Transfusion Council (SBTC) was formed in 1998 to create awareness on voluntary blood donation. The Government and charitable blood banks involving NGOs are arranging blood donation camps. Workshops are being held involving members of Indian Medical Association and Nursing Home Association, MO of all blood banks, on blood safety programme and rational use of blood. Technicians are also instructed on preventive maintenance of Elisa system. The STBC also resolved that no private blood bank should be given fresh licenses and corporate hospitals and philanthropic organization/NGOs like Rotary Clubs can only be considered after careful scrutiny. The Director, Drug Control Department has also been ordered raids of blood banks and medical shops to check the unauthorized supply of blood bags. Every blood bank is instructed to conduct all the mandatory tests, HIV, HCV, HbsAg by Elisa method in addition to the VDRL and malaria. From June 1, 2000 as per NACO guidelines, voluntary counselling and testing centres have been established in all the district headquarter hospitals and in microbiology departments of medical colleges. Surveillance centres known as Blood Testing Centres have also been established at various medical colleges to monitor the trends of the disease.

Family Health Awareness Campaigns are reportedly being held at the sub-centre level for 15 days covering the entire rural and urban slum population in the State to give counselling to all HIV-effected and their relatives about the future course of action in prolonging their lives, suggesting appropriate methods for use of condoms, proper nutritious diet and treating their psychological depression.

Ultimately, the high court issued the following directions:

1. Sufficient AIDS/HIV test kits to all hospitals and institutions shall be provided. The Government Blood banks as well as licensed blood banks should be compelled to buy fool proof HIV/AIDS test equipment;
2. All the Government hospitals should use only disposable needles in injections. Registered medical practitioners should be compelled to use only disposal syringes.
3. Bio-medical waste collected from hospitals and nursing homes should be properly destroyed or disposed of.
4. There should be more awareness programmes undertaken by the Government especially in rural areas, in slum areas so that people can take preventive measures;
5. Having regard to the cost of anti-AIDS drugs, efforts should be made to supply anti-AIDS drugs free of cost like in anti-TB and anti-leprosy programmes and family welfare programmes;
6. Doctors should be encouraged to undergo special training for diagnosis and treatment of AIDS patients;
7. There should be proper scheme for rehabilitation of patients who are diagnosed of HIV/AIDS as such persons are ostracized by their community;
8. There should be compensatory mechanism to deal with AIDS in case of negligence on part of the blood banks/hospitals by way of free facilities and free access to State funded health institution.
9. Doctrine of Constitutional tort should be recognised even for prevention and control of

AIDS and State should be made liable for any negligence on part of the health service system subject to the principles laid down in **Indian Medical Association vs. V P Shantha** (1995)6 SCC 651;

10. There should be special treatment facilities in hospitals for those who suffer from HIV/AIDS;
11. There should be strict vigilance on licensed blood banks with reference to pre-blood transfusion testing for HIV and there should be effective educational and training programmes for those who manage the blood banks.
12. The Government may consider introducing sex education in schools at least from the adolescent stage;
13. the identity of patients who come for treatment of HIV/AIDS should not be disclosed so that other patients will also come forward for treatment;
14. There should be change in the method of AIDS propaganda and no slogans promoting indiscriminate sex, should be used in the propaganda;
15. The HIV infected person should be educated about AIDS so that he may not inadvertently or innocently be responsible in spreading the disease;
16. The latest method of testing blood for HIV/AIDS should be introduced in all the hospitals by giving subsidies so that tests can be conducted at reduced costs;
17. The high court observed that the manner in which bio-medical waste are disposed off has relevance to the prevention of HIV/AIDS because such wastes includes used needles and syringes, and there is a possibility of the used syringes and needles being reused. All the hospitals and nursing homes should be directed to dispose of their bio-medical waste in terms of Bio-medical Waste (Management and Handling) Rules 1998 and they shall strictly comply with the norms specified therein. Such hospitals shall be directed to obtain the necessary authorization for disposal of the waste from PCB;
18. Like the Central Government that has exempted medicines imported for treatment of AIDS from payment of Central excise duty, the State Government should also consider the desirability of grant of sales tax exemption in relation thereto;
19. It is axiomatic that no mandamus would issue to the Legislature to enact legislation in the matter but, having regard to the submissions made at the Bar as also taking notice of the fact that Maharashtra and Karnataka have already introduced Bills in this behalf in its respective Legislature, the Government of Andhra Pradesh may also consider the desirability of introducing a similar Bill before the State Legislature.
20. The State shall issue necessary circulars to such public sector undertakings and other private sector companies to see that the person suffering from HIV/AIDS are identified and/or given proper treatment.

Pension Benefits

Ex. Const. Badan Singh vs. Union of India and Anr[11] was a case decided by the Delhi High Court in which the petitioner was a BSF Jawan who had completed six years service with the force and was detected suffering with HIV. The medical board came to the conclusion that he was unfit for further service and his service was terminated. The court after hearing the case however held that Badan Singh should be given pension.

The court held that "it could hardly be presumed that he intended to contract the fatal and stigmatic health order. No person would be happy to reap the benefits of a pension. Given a choice any person would prefer to work. It's the duty of the government to provide for health care and a pension is not a paisa more than his obligation."

Confidentiality and Right to Marry

The issue of confidentiality is very crucial for all patients. It has been separately dealt with in a later chapter of this volume.

Mr. X vs. Hospital Z[12] brought the issue of privacy before the courts. The petition dealt with

[11] 97 (2002) DLT 986
[12] AIR 2003 SC 664

two issues; firstly, right to privacy of a patient, specially an HIV/AIDS patient and secondly, the right of an individual to be safeguarded from any threat to her health.

The Petitioner was tested positive for HIV by the Respondent hospital, which acted upon the discovery and informed Petitioner's fiancée about this condition because of which the marriage was called off and his community ostracized him. Thus, this petition was filed claiming that there was a breach of privacy and confidentiality by the hospital and the doctor.

The Supreme Court observed that the relationship between doctor and patient was that of trust. No information acquired during course of treatment should be divulged without the prior permission of the patient. In case of HIV/AIDS patients, confidentiality is paramount because of repercussions of disclosure. Nevertheless, an HIV infected person has a right to lead a normal life but not at the cost of others. In the instant case the right of health of Petitioner's fiancée was pitched against his right to privacy. Supreme Court held that when two rights collide the one that promotes morality and public interest should be upheld.

Further, to condemn a person to death by transmitting AIDS not only violates his/her right to life but is also punishable under provisions of Indian Penal Code. Sections 269 and 270 of the Penal Code are as follows:

269. Negligent act likely to spread infection of disease dangerous to life- Whosoever unlawfully or negligently does any act which is, and which he knows or has reason to believe to be, likely to spread the infection of any disease, dangerous to life, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine, or with both.

270. Malignant act likely to spread infection of disease dangerous to life- Whosoever malignantly does any act which is, and which he knows or has reasons to believe to be, likely to spread the infection of any disease dangerous to life, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

The above statutory provisions impose a duty upon the person not to marry as marriage would have the effect of spreading the infection, which obviously is dangerous to life of the woman whom he marries.[13]

The hospital's act was to protect the life of another person therefore, they could not be held liable for consequences of their act. The Supreme Court said that in fact the Respondent's silence would have made them *particeps criminis* i.e. partners in crime. Has this judgement been questioned? Or is this a final verdict? Because this is totally against current practice.

The Supreme Court, however, made a further totally uncalled for observation namely that HIV/AIDS patients did not have a right to marry at all. This was going beyond the issues before the Court. This would mean that even if a person wanted to get married to another with HIV/AIDS after full disclosure she could not do so. This observation was subsequently removed by the Supreme Court on a review application.

On the issues of confidentiality in the case of **Dr. Tokugha Yepthomi vs. Appollo Hospital and Anr**[14], the Apex court held that, the timely disclosure of the HIV positive status of the patient to his fiancée saved her from being contracted with HIV and hence the disclosure did not invade the right to privacy.

Discrimination During Recruitment

The Andhra Pradesh high court in **Mr.X, Indian Inhabitant vs. Chairman, State level Police Recruitment Board and Ors**[15] observed that the clause in the revised Andhra Pradesh Police Manual

---

[13] Sections 269 & 270 ignores a situations where consummation of marriage is with the knowledge of the other partner's condition and consent.
[14] AIR 1999 SC 495
[15] 2006 (2) ALT 82

that person suffering with HIV cannot be taken into any government service was unconstitutional.

In this case, the Petitioner, an armed reserve police with the Andhra Pradesh Police, applied for the post of stipendiary cadet trainee of police (Civil). The petitioner qualified in the physical tests, completed the 5 km run within the stipulated 25 minutes and was thereafter permitted to appear in the written examination. Pursuant to the written examination held on 29-02-2004, the petitioner was provisionally selected as a sub-inspector of police. The petitioner was asked to be present on 24-6-2004, for verification and medical examination. Petitioner came to know later that he was not sent for training and was not appointed, as he had tested HIV positive.

In the high court the Petitioner contended that even though a person had been found to be HIV positive, he was fit to perform normal functions for long durations throughout the asymptomatic period, and it was only in the last stage (known as AIDS) that a person may be unfit to perform the functions or duties in his/her employment. A person's job not only provides him or her with daily sustenance but also helps to define his or her life and that most people, who are HIV positive, are fully capable of carrying out their job responsibilities and find comfort in continuing their employment, that persons with HIV positive would not put other employees at risk and as long as an HIV infected person was able to perform his job he should be treated as any other employee.

The court in its judgement held that,

The Petitioner is one among a large section of our populace living with HIV. Society has responded to their plight with intense prejudice. They have been subjected to systemic disadvantage and discrimination. They have been stigmatised and marginalized. As the present case demonstrates, they have been denied employment because of their HIV positive status without regard to their ability to perform the duties of the position from which they have been excluded. Society's response to them has forced many of them not to reveal their HIV status for fear of prejudice. This in turn has deprived them of the help they would otherwise have received. People who are living with HIV/AIDS are among the most vulnerable groups in our society. Notwithstanding the availability of compelling medical evidence as to how this disease is transmitted, the prejudices and stereotypes against persons found to be HIV positive still persist. In view of the prevailing prejudice, any discrimination against them can be interpreted as a fresh instance of stigmatization and an assault on their dignity. The impact of discrimination on persons infected with HIV is devastating. It is even more so when it occurs in the context of employment. It denies them the right to earn a living.

The court further held that,

While persons who have tested HIV positive, can be said to constitute a class distinct from others who are not so infected and to satisfy the first of the twin conditions for a valid classification, i.e., the classification being founded on an intelligible differentia which distinguishes those that are grouped together from others, it is the second condition as to whether this differentia has a rational nexus or relation to the object sought to be achieved, which requires detailed examination. As stated supra, the object is to ensure that persons appointed in the police force are of sound health and are bodily and mentally fit to discharge the duties required of officers of the police establishment. Medical evidence placed on record reveals that, in terms of physical and mental fitness, not all persons who have tested HIV positive constitute a single class, for there are different categories among them, some of whom are in the early stages of the asymptomatic period and others in the final stages and suffer from AIDS. While those in the final stages who suffer from AIDS may justifiably be denied appointment in the police establishment on the ground that they lack the required physical and mental fitness, the same cannot be said of those in the early stages of the asymptomatic period which, as stated supra, may range anywhere between 3 to 18 years, since during the prolonged asymptomatic carrier stage of HIV infection one remains fully active, physically and mentally. (MX of Bombay Indian Inhabitant (supra 1). While the medical evidence on record, of which the petitioner himself is a

classic example, would reveal that these persons with HIV positive, at the early stages of the asymptomatic period, possess the physical and mental fitness required for employment in the police establishment, no evidence to the contrary has been placed by the respondents before this court. Grouping all persons with HIV positive together for denying employment on the erroneous presumption that they all lack the high standards of physical and mental fitness prescribed for appointment to posts in the police force does not satisfy the second of the twin conditions, for a valid classification, that the differentia must have a rational nexus to the object sought to be achieved. Since a valid classification would require segregation of a group of persons with common properties and characteristics, postulates a rational basis and does not mean herding together of certain persons and classes arbitrarily, treating all HIV positive persons as one single homogenous class, irrespective of the stage of the disease, for being denied appointment in the police force is in violation of Articles 14 and 16 of the Constitution of India.

Thus the court rightly struck down the relevant provision of the AP Police Manual and held that it was discriminatory in nature and also that it denied gainful employment to persons suffering with HIV.

Liability of the State

In **P of Bombay vs. Union of India**[16] the questions raised before the Calcutta High Court were regarding the negligence of the concerned public hospital in blood transfusion through which the petitioner was infected with HIV. The union government took the responsibility for the petitioner, and gave a job and compensation of Rs 10 Lakhs to the petitioner.

In a hospital situated at Port Blair, under the administrative control of the Indian Navy, the petitioner got admitted for the purpose of delivering her child. A healthy child was delivered to the petitioner. After the delivery, the physician attending the petitioner felt that the petitioner required blood infusion. At that time there was no near relative of the petitioner present at the hospital to donate blood for the purpose of infusing the same to the petitioner. The requirement of infusion of blood was so acute, the hospital administration at the command of the attending physician arranged blood for the purpose of infusing the same to the petitioner. This blood did not come from the blood storage unit of the hospital but from a donation made by a sailor. At that time the hospital was not properly equipped to test such blood in all possible manners. The known tests were, however, conducted to find out whether the blood is otherwise safe for infusion or not. The blood was infused and later on, it transpired that it carried HIV virus. This incident, though it was an accident, occurred necessary facilities for checking for HIV were not available. Had the hospital necessary facilities the accident could have been avoided.

A writ petition was filed before the Calcutta High Court by the patient or person. Before the Petition could be decided, the Union Government accepted the responsibility for its negligence and failure and awarded a compensation of Rs. 10 Lakhs to the woman. She was also offered a job at the place she desired and also was provided with accommodation.

Aids Detection Kits

Merind Ltd. vs. State of Maharashtra[17] led the high court to hold that the AIDS detection kit falls under drugs as mentioned under the Drugs and Cosmetic Act.

The Commissioner of Sales Tax by his order dated January 7, 1998 held that any medicinal formulations or preparations for being qualified as "drugs and medicines" in the new Schedule, entry C-II-37, have not only to be useful for diagnosis, treatment, mitigation or prevention of disease or disorders, but it has also to be capable of internal or external application on the body. Since the diagnostic kits sold by the assessee were admittedly not applied on the human body either internally or externally, but were used in pathological laboratories for carrying out certain tests, the Commissioner held that in spite of the word

[16] 2001 Calcutta High Court
[17] (2004) 136 STC 462 BOM

"diagnosis" in the Schedule, entry C-II-37, with effect from October 1, 1995, the diagnostic kits would not fall under Schedule, entry C-II-37, but the same would be properly quantifiable under Schedule, entry C-II-106. It was argued before the High court that the 'Kit' falls within the definition of 'drugs' as given in the Drugs and Cosmetics Act.

The high court after considering many aspects and referring to the earlier judgements of the Sales Tax Tribunal held that, the diagnostics cannot be classified under C-I-106 which pertains to instruments but on the contrary held that the diagnostic kits are medicinal formulations used for diagnosis of the diseases in human beings, then the same would be squarely covered under entry C-II-37 and the same cannot be said to be covered under entry C-II-106.

Thus the high court negatived all the above-mentioned questions raised before it and held that the diagnostic kits can be termed as drugs and would thus be entitled to tax exemption.

Insurance

In **Rao Saheb Mahadeo Gayekwad vs. Life Insurance Corporation of India and Anr.**[18] The Insurance Company had refused to award the claim of the Petitioner as the brother of the petitioner in whose name the policy was, had died due to AIDS. The Respondent Company contended that the policyholder was fully aware of his suffering from HIV but had not disclosed this while taking the policy.

The high court held that the Respondent had not shown that the policy holder was indeed fully aware himself that he was suffering from HIV and was asked to pay the policy amount to the Petitioner.

The High Court in its order stated that,

The burden of proof is on the insurer to establish these circumstances and unless the insurer is able to do so there is no question of the policy being avoided on ground of misstatement of facts. Further for attracting the second part of Section 45 the three conditions namely (a) the statement must be on a material matter or suppress facts which it was material to disclose (b) the suppression fraudulently made by the policy-holder and (c) the policy-holder must have known at the time of making the statement that it was false or that it suppressed facts which it was material to disclose, have not been clearly made out in this case.

Conclusion

HIV/AIDS prevalence in India represents approximately 72 per cent of all prevalence in South/South East Asia. There were an estimated 5.134 million people living with HIV/AIDS in India at the end of 2004.[19] An important public interest litigation dealing with right to medical treatment of the PLWHAs was filed by the Punjab Voluntary Health Association, [20]in 2003. The petition wants the state to provide free and equitable access to antiretroviral (ARV) treatment for HIV positive persons by creating the required infrastructure in public health institutions, including the provision of trained doctors and paramedics.

The petition calls upon the Government to provide free ARV drugs to HIV positive persons. The case is pending in the Supreme Court. Broadly, this petition seeks the following:

- Recognition and implementation of the right to health and treatment of positive persons as a part of their Right to Life under Article 21 of the Indian Constitution.
- Inclusion of the above in the Government's National AIDS Control Policy.
- Free and Equitable Access of positive persons to ARV treatment under the Government's Public Health System.
- Creation of a formal and efficient infrastructure in Public Health Institutions.

---

[18] AIR 2004 KAT 439
[19] An Overview of the Spread and Prevalence of HIV/AIDS in India, **NACO publication**
[20] VHAP vs Union of India 2003 still pending in Supreme Court

Soon after the petition was filed, the Government announced free ARV drugs for one lakh people in six high prevalence States: Maharashtra, Andhra Pradesh, Nagaland Manipur, Tamil Nadu and Karnataka in December 2003. However the ground situation continues to be desperate.

The Supreme Court issued a notice to the Centre, NACO and all States and UTs on a public interest petition seeking a directive to them to provide PLWHAs the right to treatment under the country's public health system.[21]

NACO filed an affidavit in the PIL stating that only 46,000 of India's 520,000 people living with HIV receive free anti-retroviral treatment (ART) that would prevent them from developing AIDS. NACO denied that the government had ever fixed a target of giving free ART to one lakh people by 2005. Differing with the approach of the petitioners, NACO said of the 520,000 HIV-positive people in India, only 10 per cent could be said to be suffering from AIDS and needed ART. This meant that the remaining 90 per cent would have to wait and watch their infections grow into full-blown AIDS. The target of providing free ART to 3 lakh HIV-positive patients would be achieved by 2011, NACO declared in its affidavit. [22]

Over the years, one can clearly discern a progressive realization by the courts concerning HIV/ AIDS and its significance. Since in terms of a judicial time frame the issue is so new we have not confined ourselves only to cases concerning health care but have also dealt with the manner in which courts have generally dealt with the problem. In this short span of time, the courts have been confronted with all kinds of issues including discrimination in employment, access to safe blood, confidentiality and privacy. There is no statutory provision in India which safeguards the confidentiality of the individual regarding his health status, but this can be interpreted through the case laws and international instruments, which specifically state the clause of confidentiality. In India the courts have recognized the importance of maintaining confidentiality and hence in many of the cases the parties' names are either changed or only abbreviations are listed. The right to confidentiality can be interpreted through Art 21 of the Constitution of India which talks about right to life.

The above mentioned cases do not solve the problems of discrimination and isolation or accessible health care but some of the verdicts of the courts do give a ray of hope to the persons who are being discriminated on the basis of being HIV positive by the family, the employer and the society at large. Some of the judgements clearly lay down the right to be not discriminated and also the right not to be lead towards an economic death due to the disease. The State needs to do much more on the issue; similarly, the courts have to be more open and understanding in their approach while dealing with cases of persons suffering from HIV/AIDS.

Humans being what they are, in the context of a general patient refusing to be treated by an AIDS-afflicted physician or clinician, and as no law can compel him to subject himself to such treatment in the background of Articles 19(1) (*g*) and 21 of the Constitution, which are equally guaranteed to the physician too, it is difficult to answer, on the moral plane, whether a physician can be compelled to render medical service to an AIDS patient. But any decision should rest on the premise that most (at least, many) of the AIDS patients and HIV carriers are the innocent victims of an indifferent system (donees of blood, child in the womb) or the inadvertent sufferers of sexual perversions (HIV positive child prostitutes, innocent housewives), and trade and trap victims (the adolescent drug addict and the intravenous drug abuser), and therefore deserve to be considered as part of humanity, and on sufficient precaution, given medical treatment, without being discriminated and ostracised.

---

[21] Human Rights Law Network – A Profile- 2005 publication
[22] http://www.infochangeindia.org (accessed on April, 10th 2007)

*HIV (Human Immunodeficiency Virus) is a virus that attacks the immune system (Network of chemicals, cells, tissues and organ within your body that work together to fight infections and damages it. A damaged immune system cannot fight germs well. There are many stages during the HIV infection. AIDS is an advanced HIV stage. AIDS stands for Acquired Immunodeficiency Syndrome. 'Acquired' means that it originates from outside one's body and is got from someone or something and does not arise spontaneously. 'Immunodeficiency' means that the immune system or part of the immune system cannot function appropriately. 'Syndrome' means a group of symptoms. AIDS is diagnosed when the immune system is weak, as shown by a CD4count (the number of CD4 cells per milliliter of blood). It indicates how your immune system is doing. The lower the number, the greater the damage) of less than 200 cells/milliliter, or by the presence of certain opportunistic infections (Infections that would normally not happen, but that do because the immune system is weakened and cannot fight them.), for example, pneumocystis carinii pneumonia (Pneumonia caused by a fungus (a germ) called pneumocystis carinii. Pneumonia is a swelling of the tissue of the lungs.), and fungal infection of the esophagus, tumors or wasting. AIDS is the condition that results from HIV after it has done significant damage to the immune system. A person who is HIV positive (meaning a person who has HIV) does not necessarily have AIDS (she / he will progress to AIDS depending on treatment, repeated infections, etc., but a person who has AIDS is HIV positive. These conditions are irreversible.

Five

Issues in Medical Practice Care

Adv. Mihir Desai and Adv. Dipti Chand

Introduction

This Chapter tries to answer the following questions:

- What is medical practice?
- When does a person become entitled to practise medicine?
- Is cross practice permitted under the law?
- Are persons who claim to have qualifications such as electropathy, etc. that are not recognized under any law entitled to practice their respective branches?

Medical practice in a given society depends on the quantum of knowledge and also on The extent to which such knowledge is made available to society. In fact, in a welfare state, the medical needs of society accelerate the growth of knowledge in the medical sciences. If medical sciences should be attuned to the aspirations of the Indian people as outlined in the Indian Constitution, medical personnel should be oriented to the practice of the art and science of medicine, in relation to India's social structure. The control of disease must form part of the general alleviation of the social and economic ills caused by the exploitation and deliberate neglect of the Indian villager through the last few centuries.[1]

Not every person who has studied medicine has a right to practice medicine. Not every degree or diploma qualifies a person to claim that he has studied medicine. Medical profession is governed by various Central and State Acts that prescribe standard of education and practice in the interest of public and to maintain high standard of the profession. Thus, to be eligible to practice there must be absolute adherence to the provisions of concerned Acts.

Since medical practice is part of the concurrent list of the Constitution, both Central as well as State Governments can pass laws concerning medical practice. Ordinarily if the State law conflicts with the Central law, the Central law will prevail. In respect of all systems of medicine Central as well as State laws have been passed.

- The Medical Council Act, 1956 regulates modern system of medicine;
- The Indian Medicine Central Council Act, 1970 regulates Indian systems of medicine including Ayurveda, Sidha and Unani systems of medicine
- The Homoeopathic Central Council Act, 1973 regulates practice of homoeopathic medicine.

Most State Governments have also passed laws each of these branches of medicines. All these laws have schedules which list the qualifications and degrees and diplomas which would entitle practitioners to practice a particular branch of medicine. Thus, the Medical Council Act, 1956 gives a list of degrees and diplomas which are recognized for practising allopathic medicine. Similarly, say the Maharashtra Medical Practitioners Act has an additional list of degrees and diploma, available in Maharashtra that would also entitle practitioners to practice allopathic medicine. Medical Councils are set up at both Central and State levels, and these apart from their other functions also set the standards for medical ethics and parameters of medical malpractice.

[1] D. Banerji, "Medical Practice In India And Its, Sociological Implications" Antiseptic 1962, 59/2, 125-129

A major issue that the Courts have had to deal with is of cross practice. Can an ayurvedic practitioner prescribe allopathic drugs and vice versa? The common sense answer would be, no. But a large part of the primary health care sector is run by those practitioners who are registered under the ayurvedic system but have completed, what is known as, integrated medicine i.e. they have studied some amount of allopathy. The other issue concerns practice of systems of medicines that are not ordinarily recognized as the mainstream branches. These and similar issues have been raised in the Supreme Court and the high courts in the last few years.

Case Law

Cross Practice

May a homoeopath prescribe allopathic drugs?

In **Poonam Verma vs. Ashwin Patel,**[2] the Supreme Court made its famous observation:

A person who does not have the knowledge of a particular system of medicine but practices in that system is a quack and a mere pretender to medical knowledge or skill, or to put it differently, a charlatan.

The Court went on to observe that no person can practice a system of medicine unless he is registered either under the Central Indian Medical Register or the State Register to practice that system of medicine; and only such persons as are eligible for registration and possess recognised degrees as specified under the concerned Central and State Act may so practice. The mere fact that during the course of study some aspects of other systems of medicine were studied does not qualify such practitioners to indulge in the other systems.

In this case, a registered homoeopathy doctor prescribed allopathic medicines to Poonam Verma's husband. His defence was that he had received instructions in modern system of medicine (allopathy), and after the completion of his course, he had worked as Chief Medical Officer at a well-known allopathic clinic.

The Supreme Court observed that a registered homoeopathic practitioner could only practice homoeopathy. Further the Court opined that

...physiology and anatomy is common in all systems of Medicines and the students belonging to different systems may be taught physiology and anatomy together, but so far as the study of drugs is concerned, the pharmacology of all systems is entirely different. Therefore, merely because the anatomy and physiology are similar does not entitle a person who has studied one system of medicine to treat patients under another system.

The Court held that the doctor was registered only to practice homoeopathy. He was under a statutory duty not to enter other systems of medicine. He trespassed into a prohibited field and was liable to be prosecuted under Section 15(3) of the Indian Medical Council Act, 1956. His conduct also amounted to an actionable negligence for any injury caused to his patients in prescribing allopathic drugs.

May an ayurvedic doctor prescribe allopathic drugs?

In **Mukhtiar Chand (Dr.) vs. State of Punjab**[3] the primary question before the Supreme Court was "who may prescribe allopathic medicines?" This case raises questions of general importance and practical significance; questions relating not only to the right to practice medical profession but also to the right to life that includes the health and well-being of a person.

The controversy in these cases was triggered by the issuance of declarations by the state Governments under clause (iii) of Rule 2(ee) of the Drugs and Cosmetics Rules, 1945 (for short 'the Drugs Rules') which defines "Registered Medical Practitioner". Under such declarations,

---

[2] (1996)4 SCC 332
[3] (1998)7 SCC 579

notified vaids/hakims claim right to prescribe Allopathic drugs covered by the Indian Drugs and Cosmetics Act, 1940 (for short 'the Drugs Act'). Furthermore, vaids/hakims who have obtained degrees in integrated courses claim right to practise allopathic system of medicine.

In exercise of the power under clause (iii) of Rule 2(ee) the State of Punjab issued a notice declaring all the Vaids/Hakims who had been registered under various medical acts[4] as persons practising modern System of Medicine for purposes of the Drugs Act. One Dr. Sarwan Singh Dardi who was a medical practitioner, registered with the Board of Ayurvedic and Unani System of Medicines, Punjab, and who was practising modern system of medicines was served with an order of the District Drugs inspector, Hoshiarpur, prohibiting him from keeping in his possession any allopathic drug for administration to patients and further issuing general direction to the chemists not to issue allopathic drugs to any patient on the prescription of the said doctor. Dr.Dardi claimed that he was covered by the said notification and was entitled to prescribe allopathic medicine to his patients and store such drugs for their treatment (hereinafter referred to as Dardi's case). The Court held that the said notification was ultra vires the provisions of sub-clause (iii) of clause (ee) of rule 2 of the Drugs Rules and also contrary to the provisions of Indian Medical Council (IMC) Act, 1956 and accordingly dismissed his writ petition.

Now what does the rule 2(ee) say? It defines 'registered medical practitioner' as a person-

i) holding a qualification granted by an authority specified or notified under Section 3 of the Indian Medical Degrees Act, 1916, or specified in the Schedules to the Medical Council Act, 1956; or
ii) registered or eligible for registration in a Medical Register of a State meant for the registration of persons practicing the modern scientific system of medicine (excluding the homoeopathic system of medicine); or
iii) registered in a Medical Register (other than a register for the registration of homeopathic practitioner) of a State, who although not falling within sub-clause (i) or sub-clause (ii) is declared by a general or special order made by the State Government in this behalf as a person practicing the modern scientific system of medicine for the purposes of the Act.

Through this petition, the doctors sought to reinforce their right to prescribe allopathic medicine on the strength of the notification and restrain State authorities from interfering with such a right. Similar issues also arose in various other high courts and finally all the cases reached the Supreme Court. The Apex Court observed that the Rule 2(ee) only defines the expression 'registered medical practitioners' and does not provide as to who can be registered. Therefore, the Court read the notification in consonance with laws regulating and permitting medical practice.

As a rule medical practitioner can practice in that system of medicine for which he is registered as a medical practitioner. Under the IMC Act, 1956 there are two types of registration: under 'State Medical Register' and 'Indian Medical Register'.

According to Section 15(2) of the IMC Act only those who are enrolled in any State Medical Register can practice allopathic medicine in the State. Section 15(1) provides that qualifications specified in the Schedules of the Act shall be sufficient for enrolment in the State Medical Register. However, such qualification is not a necessary pre condition for registration. 'State Medical Register' is a contradistinction to 'Indian Medical Register' and is maintained by the State Medical Council constituted under any State law that regulates the registration of medical practitioners. It is thus possible that in a State, the law governing registration may enable a person to be enrolled on the basis of qualifications other than the 'recognized medical qualification'. On the other hand, 'recognized medical qualification' is a perquisite for enrolment in Indian Medical Register.

To summarise, persons holding 'recognized medical qualification' cannot be denied

[4] East Punjab Ayurvedic and Unani Practitioners Act, 1949, and Punjab Ayurvedic and Unani Practitioners Act, 1963 Pepsu Ayurvedic and Unani Practitioners Act, 2008 BK

registration in any State Medical Register, but the same cannot be insisted upon for registration in a State Medical Register. Further, a person registered in a State Medical Register cannot be enrolled on the Indian Medical Register unless he possesses 'recognized medical qualification'.

The Indian Medicine Central Council Act, 1970 has made a similar distinction between 'State Register' and 'Central Register of Indian Medicine'. Section 17 of the Act provides the recognized medical qualification for enrolment in the State Register, and that no person other than those who are enrolled either on the State register or the Central Register of Indian Medicine can practice Indian medicine. Section 17(3) carves out exceptions to this prohibition and protects, inter alia-

(a) The right of a practitioner of Indian Medicine enrolled on a State Register of Indian Medicine to practise Indian medicine in any State merely on the ground that, on the commencement of this Act, he does not possess a recognised medical qualification.
(b) Privileges including the right to practice any system of medicine which was conferred by or under any State law relating to registration of practitioners of Indian Medicine for the time being in force, on a practitioner of Indian Medicine who was enrolled on a State register of Indian Medicine.
(c) The right of a person to practise Indian medicine in a State in which, on the commencement of this Act, a State Register of Indian Medicine is not maintained if, on such commencement, he has been practising Indian medicine for not less than five years.

Thus, a harmonious reading of Section 15 of the IMC 1956 Act and Section 17 of 1970 Act leads to the conclusion that a medical practitioner of Indian Medicine enrolled on the State Register of Indian Medicine or the Central Register of Indian Medicine can practice modern scientific medicine only if he is also enrolled on a State Medical Register within the meaning of Section 15(2) of the 1956 Act.

The Supreme Court held that benefit of Rule 2(ee) and the notifications issued there under would be available in those States where the privileges to practice any system of medicine is conferred upon by the State law for the time being in force, under which medical practitioners of Indian Medicine are registered in the State.

Lastly, doctors urged that integrated courses in ayurvedic medical education includes to an extent the study of modern scientific system of medicine. The right to practice a system of medicine is derived from the Act under which a medical practitioner is registered; whereas the right which the holders of a degree in integrated courses of Indian Medicine are claiming is to have their prescription of allopathic medicine honoured by a pharmacist or a chemist under the Pharmacy Act and Drugs Act. The Supreme Court held that the right to prescribe drugs is a concomitant of the right to practice a system of medicine. Appellants cannot claim such a right when they do not possess the requisite qualification for enrolment in the State Medical Register.[5]

In **Subhashis Bakshi vs. W.B.Medical Council & Ors**[6] the Court reiterated that State Governments were at liberty to decide the on qualifications that would permit prescription of allopathic (as also other) medicines in the State. The other issue before the court was whether the right to issue prescriptions or certificates could be treated as a part of right to treat. The court, relying on Mukhtiar Chand's case held that right to prescribe drugs and the right to issue certificates is concomitant to the right to practice medicine. This was a case where the West Bengal Government had allowed certain diploma holders to practice medicine to a limited extent in rural areas. As per the Supreme Court's order this was continued.

May allopathic doctor prescribe ayuvedic drugs?

The **Akhtar Hussain Delvi (Dr.) vs. State of Karnataka**[7] case dealt with a situation quite

[5] Even if a non-allopathic medical practitioner does not have the right to practice allopathic medicine, he can prescribe allopathic medicine that are sold across the counter for common ailment. (p. 597 para 41)
[6] (2003) 9 SCC 269
[7] AIR 2003 Karnataka 388

opposite to the earlier cases. Here, a registered allopathic medical practitioner sought the right to prescribe drugs and medicines of ayurvedic origin, which had been accepted by professionals practising allopathic medicine pursuant to clinical and other tests. The high court observed that under the Indian Medicine Central Council Act, 1970 only those who either possess medical qualifications specified in Second, Third or Fourth Schedule of the Act or are enrolled in the State Register of Indian medicine have right to practice Indian medicine. The Petitioner neither had acquired such a qualification nor passed qualifying examination under the concerned State Act, and therefore, was not entitled to prescribe ayurvedic medicine.

Standard of Education

The Medical Councils constituted under different Central and State Acts are sole statutory bodies under their respective Acts and regulate the course of admission, standard of education and quality of practice. Provisions made by the Medical Council in the exercise of such powers can neither be transgressed by any authority nor are they subject to judicial review unless the Act itself provides certain exceptions and confers or delegates any power to any other authority.

Issue of pharmacy courses:

In **Basavaraj M. vs. Karnataka State Pharmacy Council,** [8] the Court was looking into a job-oriented Diploma in Pharmacy Vocational Courses from 1993 to 1995 under the Centrally Sponsored Scheme of providing vocational courses at secondary education level conducted by the Karnataka State. The course was not recognized by Pharmacy Council of India, a statutory body constituted under Pharmacy Act, 1948 to determine the course, to regulate admission, standard and examination. Petitioners' grievance was that they had been denied registration on the basis of Diploma Certificate that was granted by the State Government. Under the Pharmacy Act, 1948 only those who have passed the approved examination or possess qualification that has been approved under Section 14 or is registered as Pharmacists in another state are eligible for registration. The high court held that since the Pharmacy Council of India was the sole authority governing the standard of education and practice in pharmacy, the State Government was not competent to run such a course without proper and due approval from it. If a course is run without the requisite approval of the statutory body then certificates or diplomas received are not valid and will not entitle persons like the Petitioners to claim registration. It is of no consequence whether the State Government or any authority acting under it has granted such diplomas. Identical orders were passed in the case of **Shivraj Singh vs. State of Uttaranchal**[9] by the high court in respect of Pharmacy courses run by the Government of Uttar Pradesh. Which had not been recognized by the Pharmacy Council.

Recognition of a medical degree:

The **Delhi Pradesh Registered Medical Practitioners vs. Director of Health, Delhi Admn. Services**[10] was a Petition filed against the decision of the Indian Medicine Central Council constituted under the Indian Medical Central Council Act, 1970 denying recognition to the degree in Indian medicine awarded by Hindi Sahitya Sammelan after 1967. The Appellants' case was that:

1. The Institution in question was very old and reputed, and on the basis of degrees awarded by it, large number of practitioners in the discipline of Ayurveda had been registered in various States including Delhi and have been successfully practicing in the discipline of Ayurveda.
2. In the absence of proper medical facilities available to a large number of poorer sections of society, the ban on practitioners who were providing medical services to the needy and poor people was wholly unjustified.

The Supreme Court, however, refused to review the decision of the Indian Medical Central Council merely on the basis of the above submission as it

[8] AIR 2001 Karnataka 239
[9] AIR 2005 UTR 39
[10] (1997)11 SCC 687

fell within the realm of policy decision of constitutional functionaries who had the requisite knowledge and expertise to take such decisions. Thus, the degrees were not recognized.

The courts have by and large left it to the expert bodies such as Medical Councils to decide as to which qualifications should be recognized and which should not be.

Unlicensed Practitioners

Practising Different Systems of Medicine:

In **State of Tamil Nadu vs. M.C. George**[11] decided by the Tamil Nadu High Court the Petitioner was a hereditary practitioner of Siddha medicine. He had been practising Siddha since the mid-1960s after learning it from his father, and was very popular with the villagers. In 1981 the Tamil Nadu Government issued a notification asking people who were practising Indian system of medicine to register. The Petitioner delayed the matter and was not granted registration. He challenged this in the high court. The Division Bench said that the Petitioner did not have any need to register himself since under the Indian Medicine Central Council Act, if a person had been practising Indian medicine for a period of five years at the time of the commencement of the Act; he had a right to continue practising Indian medicine. The Court held that the Petitioner could continue to practice Siddha without registration. It needs to be noted of course, that this right is only for those who were already practising Indian medicine for five years at the time of commencement of the law and not the subsequent entrants.

The Court also observed:

> Before dealing with the facts of this case, it may be mentioned that in our country, like in other countries, since ancient times medicine has been practiced and a medical system has been evolved. We had renowned medical practitioners like Sushrut and Charak who are internationally known. In fact, no society can get along without medical practitioners. In every society some people fall sick and get diseases, thus requiring medical treatment. In our country, the Siddha, Ayurveda and Unani systems were evolved, which were traditionally indigenous systems of our country. Medical practitioners of these systems would often pass all their medical knowledge to their children or disciples and often this knowledge were kept secret from others. Thus, this knowledge was passed on from generation to generation, but it was only given to the children or the devoted disciples and kept secret from others. Many of the treatments in our indigenous medical systems are very effective and there is no reason why we should not utilize the wisdom of our ancestors.
>
> In our opinion, we should encourage indigenous systems of medicines, though with scientific discrimination and after experimentation. However, it is also important that quackery should be suppressed, because it is also true that quackery is widely prevalent in our country, as poor people often cannot afford the fees of qualified doctors. Hence, a balance has to be maintained.

In **Private Medical Practitioners Association of A.P. vs. State of Andhra Pradesh**,[12] the State Government issued a notification prohibiting all unlicensed practitioners from practising medicine. The association representing the unlicensed practitioners challenged the notification in the high Court. Its contention was that they were mainly practising in rural areas and were of great help to the poor villagers. The high court, however, dismissed their Petition holding that unless a person had the qualifications prescribed under one of the medical laws he did not have the right to practise medicine.

In the case of **Electropathy Medicos of India vs. State of Maharashtra**[13] a college was conducting a three year course in electropathy, a branch of medicine contended to be different from

[11] W.A. No. 108 of 2005 and W.A.M.P. No. 153 of 2005, decided on 24.03.2005
[12] Writ Petition 15410 of 1995, decided by the AP High Court on 8.4.2002
[13] Decided by Bombay High Court on 13.8.2001

homeopathy, ayurveda and allopathy. The State Government had issued a notification directing that such a course was not recognized and no degrees or diplomas could be offered. The Petitioners contended that electropathy was founded in the 19th Century in Italy and provided a sound system of medical practice. The high court, however, rejected this and ordered:

(i) The petitioner-society is directed to close down all courses in electropathy/ electro-homoeopathy forthwith.
(ii) The petitioner-society is directed not to grant affiliation and/or recognition to any college or institution.
(iii) The petitioner-society is hereby directed to refund the fees received from the students admitted by the petitioner-society for its 3 years diploma courses as well as one year diploma course with interest at the rate of 18% p.a. within 3 months.
(iv) The State Government is directed to close down all institutions in the State holding the course in electropathy or electro-homoeopathy and to take action against the electropathy practitioners in accordance with the provisions of the Maharashtra Medical Practitioners Act, 1961.

A similar case concerning electropaths and electrohomeopaths in **Uttar Pradesh vs. Electro Homeopathic Practitioners Association of India**[14] a Division Bench of Allahabad High Court was asked to permit electrohomeopaths to continue to carry on their profession. The court rejected this contention and held that unless a system of medicine was recognised by the legislature it could not be allowed to continue. Upon this, the Association claimed that its members were not practising medicine. The Court, while rejecting this contention held:

Shri U. K. Shandilya. Learned sr. counsel for the appellants then submitted that the members of the petitioner's Association are not practising medicine, and hence they cannot be debarred from practice. We cannot agree. Chambers English Dictionary defines medicine to mean "the art or science of prevention and cure of disease." Thus, medicine is that knowledge which is used for curing the aliment of the human body. Since the petitioners claim that their activities are aimed at curing the ailment of the human body there can be no doubt that they claim to be practising medicine. It is of course a different matter that their claim has not been accepted by the expert committee appointed by the Central Government.

The Court directed the State to restrain the practice or teaching of electrohomeopathy throughout the State.

Quacks:

In the case of **D.K.Joshi vs. State of U.P.**,[15] public interest litigation was filed demanding that the State Government take steps to stop unqualified practitioners from practising in Agra and the surrounding areas. The Court felt that adequate steps were not taken by the administration and issued directions in respect of the entire state as follows:

The Secretary, Health and Family Welfare Department, State of U.P. shall take such steps as may be necessary to stop carrying on medical profession in the State of U.P. by persons who are unqualified unregistered and in addition shall take followings steps:

(i) All District Magistrates and the Chief Medical Officers of the State shall be directed to identify, within a time limit to be fixed by the Secretary, all unqualified/unregistered medical practitioners and to initiate legal actions against these persons immediately.
(ii) Direct all District Magistrates and the Chief Medical Officers to monitor all legal proceedings initiated against such persons;
(iii) The Secretary, Health and Family Welfare Department shall give due publicity of the names of such unqualified/unregistered medical practitioners so that people do not approach such persons for medical treatment.
(iv) The Secretary, Health and Family Welfare Department shall monitor the actions taken by all District Magistrates and all Chief Medical Officers of the State and issue

[14] 2004 4 AWC 3148
[15] Civil Application No. 2016 of 1996 decided by the Supreme Court on 25.4.2000

necessary directions from time to time to these officers so that such unauthorised persons cannot pursue their medical profession in the State.

In the case of **Charan Singh vs. State of U.P.**,[16] the Allahabad High Court was concerned with practitioners having degrees from unrecognised colleges. This arose as a follow up of the D.K. Joshi case cited above. The court came down heavily on these practitioners and held that they had no right to practise medicine. Similarly, it also ordered the State Government to close down unrecognised institutions. Besides this, the court repeated the directions earlier issued by it meant to ensure that only registered medical practitioners practiced in the State. Towards this the Court directed:

(1) All the Hospitals, Nursing Homes, Maternity Homes, Medical Clinics, Private Practitioners, practising medicine and offering medical and health care services, Pathology Labs, Diagnostic Clinics; whether run privately or by firms, Societies, Trusts, Private limited or Public limited companies, in the State, shall register themselves with Chief Medical Officer of the District where these establishments are situate, giving full details of the medical facilities offered at these establishments, the names of the registered and authorised medical personnel practising, employed or engaged by them, their qualifications with proof of their registrations, the Para Medical staff employed or engaged and their qualifications, on a form (for each category) prescribed by the Principal Secretary, Medical Health and Family Welfare, Government of U. P. The prescribed pro forma with true and accurate information shall be submitted, supported by an affidavit of the person providing such medical services of the person in charge of such establishment, sworn before Notary Public. The required information shall be submitted for registration, by al these persons, on or before 30-4-2004.

(2) The principal Secretary, Medical Health and Family Welfare, U. P. shall publish the information requiring all the persons to obtain registrations, along with the directions given in this order, and the prescribed pro forma, in all leading newspapers of the State, at least three times, in the month of February, 2004.

(3) Any change or addition in the particulars submitted shall be notified within thirty days and that the registrations shall be renewed every year before 30th April of the year.

(4) On and from 1-5-2004, all those persons who have not furnished the information and obtained registration with the Chief Medical Officers of the District, shall be taken to be practising unauthorised and that the Chief Medical Officers, shall scrutinize and forthwith report the matter to the Superintendent/Senior Superintendent of Police of the District with information to this Court, to conduct raids and to seal the unauthorised premises/ establishments. All the authorised persons/ establishments, who fail to obtain registration, will have liberty to apply only to this Court to explain the delay and to seek permission to continue with their medical practice/ profession.

(5) All those medical practitioners who desire to offer medical services in the State, in future, shall be required to submit the details in the aforesaid pro forma for registration as above with the Chief Medical Officer of the district before they start medical practice.

(6) All the institutions/establishments/ colleges awarding medical degree in the State shall apply and get themselves with the Principal Secretary Medical Health and Family Welfare, U. P. with full particulars of their authorization to confer such degrees/ certificates, on or before 30-4-2004.

(7) The news papers and magazines, published in Uttar Pradesh, are restrained from publishing advertisements by and from unauthorised medical practitioners, publishing their claims of quick and magical remedies. They shall require these persons to give proof of their qualifications and registrations. The breach shall be taken to aid and obviate illegal activities violative of Magic Remedies (Objectionable Advertisement) Act, 1954, and other relevant legislations.

(8) The Principal Secretary, Medical Health and Family Welfare, it is directed, to ensure that no medical officer in the Government Service

[16] AIR 2004 ALL 373

is posted beyond three years in any District, and that all para medical staff serving in the Primary Health Centre/Community Health Centre/District Hospitals and other hospitals run by Government of U.P. for more than five years shall be transferred from that centre/ hospital. Any doctor in employment of State Government offering their services to the unauthorised medical practitioners shall face immediate disciplinary action by the State Government, and shall be prosecuted for aiding and abetting such unauthorised practice.

In the case of **Shri Sarjoo Prasad vs. State of Bihar**[17] the Patna High Court was concerned with the right of practice of occupational therapists/ physiotherapists. To begin with, after studying the literature in detail the court held that occupational/ physiotherapy is a recognized form of medical practice. However, the court further observed that unless the concerned qualification finds a place in the schedule to the Medical Council Acts and the holders of the qualifications are registered under that Act, they have no right to practice modern scientific medicine or prescribe allopathic drugs.

Certificate for medical practice

An issue that has been constantly coming up especially in States like Maharashtra concerns registered practitioners of other States. In states like Bihar, the practice of medicine is permitted even without any formal qualifications, if one is able to satisfy certain basic criteria. A number of persons from Maharashtra, for instance, go to Bihar and get these Certificates and start practising medicine in Maharashtra. Similarly, in a recent case in Maharashtra, the Petitioners were registered in Bihar and Uttar Pradesh but not in Maharashtra. They were not registered under the Central Acts. Their qualifications were recognised under the Bihar and the Uttar Pradesh laws, but not under the Maharashtra or the Central laws. The Maharashtra law entitles only those who are either registered in Maharashtra or under the Central law to practice in Maharashtra. The Court found nothing wrong with this law and held that merely because a person is registered under any other State medical law does not entitle him to practice in Maharashtra unless he is registered in the State (i.e. his qualification is recognized in Maharashtra) or under the Central law (i.e. his qualification is recognized by the Central Council).

Conclusion

India is a place where various systems of medicine are practised. The legislature however recognizes five main systems, namely allopathy, ayurvedic, unani, siddha and homeopathy. In order to practise medicine, the practitioner has to have a recognized qualification from a recognized institute. In all other cases, the practice of medicine is prohibited. The law does not recognize an inherent right to practise medicine, but is subject to national and state laws.

An interesting issue that has not come up concerns specializations. There is no law that prevents a person who has only an MBBS (and not MD or MS) degree from practising and even setting up as a specialist in cardiology or ENT, etc. Of course, if a case of negligence is filed against the practitioner, he may be held guilty on account of holding himself out to be an expert in a subject in which he has not acquired such an expertise. But that is only if a case of negligence is filed against him. On the other hand, not having the basic recognized qualification disentitles a person altogether from practising that branch of medicine and this will not be contingent upon any case being filed against him.

In **M. Jeeva vs. R. Lalitha,**[18] the National Consumer Commission has dealt with the case of a woman running a gyneacological hospital for 40 years. The Complainant gave birth to a dead child and her uterus was removed. The person running the hospital and performing procedures and administering treatment was a qualified nurse and midwife but not qualified to practise medicine. The complainant was awarded a compensation of Rs. 2 lakh.

---

[17] 2003 1 BLJR 686
[18] 1994 2 CPJ 73

The courts have been mainly concerned with cross practice and of certain non recognized systems of medicine. Cross practice has not largely been allowed though there are certain exceptions. Similarly, uniformly the courts have come down heavily against unrecognized degrees or qualifications granted by unrecognized institutions. The courts have also refused to recognize other systems of medicine such as electropathy, etc. Every medical practitioner has a "right to treat" and every patient has a right to say: "treat me, treat me well." That depends on one's qualification, knowledge, skill and experience. A degree for qualification is no guarantee of knowledge or skill.

Justice Suresh [19] feels that it is 'quackery' that is to be taken care of. Quacks are unqualified practitioners who falsely claim to possess a degree in medicine and prescribe drugs, licensed or unlicensed. Hidden quackery occurs in 'doctors' clinics that acquire legitimacy through fake degrees and registration acquired through bribery, etc. and those that claim Tantric powers to cure by miracles. India is otherwise short of registered medical practitioners. According to UNDP *Human Development Report*, 2003, India has 48 physicians for 1, 00,000 people. This is grossly inadequate. We have to have more people duly qualified to provide medical care with a short term course – may be with an Integrated Medical Course – who can go to villages and small towns, so as to make access to health and health care for all a reality.

As part of the strategy to mainstream AYUSH (Ayurveda, Unani, Siddha, and Homeopathy Systems etc.) and reinforce healthcare delivery through the primary health network, the Government has decided to appoint AYUSH doctors in PHCs and Community Health Centres. Initially, AYUSH doctors and medicines would be made available in single doctor PHCs and two-doctor Community Health Centres in every district. Tamil Nadu and Kerala that have such integrated health services have shown the usefulness of these, in improving health delivery. The Government has taken measures to mainstream and integrate AYUSH and provide choice and cross-referral facilities to the public under one roof.[20] The issue of cross malpractice needs to be addressed by strengthened regulatory mechanisms, which should be developed within the framework of various systems of medicine. The fact that AYUSH practitioners may be the only accessible practitioners in many rural and semi-rural areas needs to be recognised and taken into account while attempting to undertake standardisation.

---

[19] Quote by Justice Suresh, who is a former High Court judge, presently involved in human rights activism
[20] Press Information Bureau, Press Release dated Nov 13 , 2005

Six

Medical Negligence

Adv. Mihir Desai and Adv. Dipti Chand

Introduction

This Chapter aims to discuss the following:

- What is meant by medical negligence?
- What are the available remedies for victims of medical negligence?
- What have been the recent trends of the judiciary in the matters pertaining to medical negligence and deficiency in medical services?

Negligence can be described as failure to take due care, as a result of which injury ensues. Negligence excludes wrongful intention since they are mutually exclusive. Carelessness is not culpable or a ground for legal liability except in those cases in which the law has imposed the duty of carefulness. The medical profession is one such section of society on which such a duty has been imposed in the strictest sense. It is not sufficient that the medical professional acted in good faith to best of his or her judgement and belief. A medical professional is expected to have the requisite degree of skill and knowledge The question in every case would be whether the medical practitioner in fact attained the degree of due care established by law. Medical negligence is a sub species of this tort (civil wrong) which falls within the larger species of professional negligence. Under our law, medical negligence, like other forms of negligence, is a criminal offence for which a doctor can even be imprisoned. This is so in many other legal systems also. Medical malpractice, however, is not merely the negligence on the part of the care giver; it is a conscious decision of the care giver to offer and/or force a product, procedure or investigation upon a patient for monetary gain either personally or for the institution.

But what amounts to medical negligence? Is there a difference between how civil law and criminal law define negligence? Till 2004, it was generally believed that though civil law and criminal law provided for different remedies, what constituted negligence under both these laws was the same. However recent decisions of the Supreme Court have taken a different view.

There are three essential components of negligence:

- The existence of a duty to take care, which is owed by the doctor to the complainant;
- The failure to attain that standard of care, prescribed by the law, thereby committing the breach of such duty;
- Damage, which is both causally connected with such breach and recognized by the law, has been suffered by the complainant.

This is the ordinary legal meaning of negligence. But for professionals such as medical practitioners an additional perspective is added through a test known as the Bolam test which is the accepted test in India. In the case of **Bolam vs. Friern Hospital Management Committee,**[1] the Queen's Bench Division of the British Court held:

A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

---

[1] 1957 2 ALL ER 118

As set out in the judgment of the Supreme Court in the case of **Jacob Mathew vs. State of Punjab**[2]

The standard of care, when assessing the practice as adopted is judged in the light of the knowledge available at the time (of the incident), and not at the date of trial.

When the charge of negligence arises out of a failure to use some particular equipment, the charge would fail if the equipment was not generally available at that point of time on which it is suggested as should have been used.

In this decision the Supreme Court also observed that for inferring negligence on the part of a professional, including a doctor, additional considerations apply.

A simple lack of care, an error of judgment or an accident, is not proof of negligence on the part of a medical professional. So long as a doctor follows a practice acceptable to the medical profession of that day, he cannot be held liable for negligence merely because a better alternative course or method of treatment was also available or simply because a more skilled doctor would not have chosen to follow or resort to that practice or procedure which the accused followed.

Finally, while dealing with negligence the Supreme Court made the following observations:
A professional may be held liable for negligence when

a) He was not possessed of the requisite skill which he professed to have possessed; [and/ or]
b) He did not exercise, with reasonable competence in the given case, the skill, which he did possess.

The standard to be applied for judging whether the person charged has been negligent or not would be that of an ordinary competent person exercising ordinary skill in that profession. It is not possible for every professional to possess the highest level of expertise or skills in that branch which he practices."

All the three remedies can be resorted to simultaneously.

Case Law

Criminal Negligence

As regards criminal liability of medical practitioners, Supreme Court in a recent judgment in the case of **Dr. Suresh Gupta vs. Govt. of Delhi**[3] curtailed criminal proceedings against medical negligence to incidents of *gross* negligence. It held that a medical practitioner cannot be held punishable for every mishap or death during medical treatment.

No criminal liability should be attached where a patient's death results from error of judgment or an accident. Mere inadvertence or some degree of want of adequate care and caution might create civil liability but would not suffice to hold him criminally liable.[4]

The degree of medical negligence must be such that it shows complete apathy for the life and safety of the patient as to amount to a crime against the state. The issue has been more elaborately dealt with in the case of Jacob Mathew discussed above.

In Suresh Gupta's case, the patient died while he was being operated for nasal deformity, a minor operation without much complexity. The medical experts of the prosecution testified that the cause of death was due to the failure of the Appellant to introduce a cuffed endotracheal tube of proper size to prevent aspiration of blood from the wound in the respiratory passage. The Supreme Court held that even if it was assumed that the Appellant was negligent, he would not be criminally liable as the alleged act was not grossly negligent. At the most he was liable in tort for damages but not for imprisonment under the criminal law.

The Court expressed concern that if the liability of doctors were unreasonably extended to criminal liability thereby exposing them to the risk of landing

[2] (2005) 6 SCC 1
[3] (2004) 6 SCC 422
[4] (2004) 6 SCC 429, para 21

What are the various remedies available under the Indian law in case of medical negligence? Broadly, there are three remedies available:

CIVIL SUIT CONSUMER COURT	CASE IN MEDICAL COUNCIL	CASE OF CRIMINAL NEGLIGENCE
Civil Remedy where the relief is sought in compensation under the Consumer Protection Act 1985	A case against a doctor can be filed in Medical Council of the concerned system of medicine	The main section under which a criminal case is filed against doctors is Section 304B of the Indian Penal Code which deals with causing death due to rash and negligent act The punishment is two years imprisonment or fine or both.
Cases deal in medical negligence and medical practice	Medical Councils do not have powers to award compensation or to imprison	Similarly, S.336 of the Penal Code provides that it is an offence to endanger the human life or personal safety of others through a rash or negligent act. The punishment is three months imprisonment or fine of Rs. 250 or both
	It can only warn the doctor, suspend or revoke the license	S. 337 and 338 of the Indian Penal Code make it an offence to cause simple hurt or grievous hurt through rash or negligent act. The punishment can be upto six months of imprisonment or fine upto Rs. 500 or both for simple hurt and punishment upto 2 years or fine upto Rs. 1000 or both for causing grievous hurt.

themselves in prison for alleged criminal negligence then the repercussion would be that the doctors would be worried about their own safety rather than administering treatment to the best of their ability. The Court felt that this would adversely affect the society at large and shake the mutual confidence between the doctor and the patient.

Even where gross negligence is alleged, a prima facie case must be established before a magistrate at the first instance as was pointed out in **Dr. Anand R. Nerkar vs. Smt Rahimbi Shaikh Madar**[5]

It is necessary to observe that in cases where a professional is involved and incases where a complainant comes forward before a Criminal Court and levels accusations, the consequences of which are disastrous to the career and reputation of adverse party such as a doctor, the court should be slow in entertaining the complaint in the absence of the complete and adequate material before it. It is always open to the learned magistrate to direct an enquiry through the police so that all relevant aspects of the case are looked into before process is issued.... the duty cast on the trial Magistrate under Section 202 of the Criminal procedure Code is not to be understood as being confined to ascertain as to whether the complainant and the witnesses have mechanically averred that the accused has committed an offence, but it presupposes that judicial mind will apply itself to the case made out as a whole and conclude as

[5] 1991(1) Bom. C.R. (p. 629)

to whether there is sufficient justification to hold that an offence has been committed. The establishment of a prima facie case, therefore, indicates that on the face of the record all ingredients that would constitute the commission of an offence are before the court. Where there exist serious lacunae in the case made out and where the possibilities and probabilities of an adverse conclusion are remote, it would not be justified in holding that a prima facie case has been made out.

So far so good. But what the Supreme Court did in the Jacob Mathew's case[6] was to hold that the ingredients of criminal negligence were more rigorous than those of civil negligence. In addition to the ingredients of civil negligence for establishing criminal negligence

...it shall have to be found that the rashness was of such a degree as to amount to taking a hazard knowing that the hazard was of such a degree that injury was most likely imminent...Where negligence is an essential ingredient of the offence the negligence to be established by the prosecution must be culpable or gross and not the negligence merely based upon an error of judgment....criminal negligence is the gross and culpable neglect or failure to exercise that reasonable and proper care and precaution to guard against injury... .

The Supreme Court also laid down guidelines for prosecuting doctors:

1. A private criminal complaint should not be entertained unless the complainant has produced prima facie evidence in the court in the form of a credible opinion given by another competent doctor to support the charge of rashness or negligence.
2. The investigating officer, before proceeding against a doctor, should obtain an independent medical opinion preferably from a doctor in government service qualified in that branch of medical practice.
3. The accused doctor should not be arrested in a routine manner unless his arrest is necessary for furthering investigation or for collecting evidence or unless the investigating officer feels satisfied that the doctor will abscond.

This judgment in fact amounts to a stretched interpretation of the words of the legislation and placing doctors on a relatively higher pedestal when the law itself does not make any such distinction.

Jurisdiction of Consumer Courts

Medical negligence gives rise to civil and criminal liability. We have already mentioned that as regards civil wrongs, an aggrieved person can claim compensation either through a civil suit or a complaint lodged with consumer forum. Since the enactment of Consumer Protection Act, 1985 there has been a significant rise in medical negligence cases being filed. In one sense, the passing of this law has given a boost to consumers for approaching courts in respect of negligence. Before we go into substantial aspects of medical negligence it is important to see how the Courts have interpreted the Consumer Protection Act and its jurisdiction. Doctors have raised a number of concerns regarding the applicability of Consumer Protection Act. Wide ranging issues from applicability of the Act to medical practitioners, the nature of medical services which would be covered by the Act, the nature of consumers (i.e. patients) who would be covered by the Act have been litigated. Since this is the law most used by patients and their relatives, it becomes important to first see whom it applies to.

For quite some time after the passage of the Consumer Protection Act, furious debate was raging whether it at all applies to doctors, hospitals and nursing homes and if so under what situations. The Supreme Court finally set at rest this controversy in the case of **Indian Medical Association vs. V.P. Shantha**[7]. The Court held that proceedings under the Consumer Protection Act are summary proceedings for speedy redressal and the remedies are in addition to private law remedy. The issue was whether patients are

---

[6] ibid

[7] (1995) 6 SCC 651

consumers under the Consumer Protection Act and could they claim damages for injury caused by the negligence of the doctor, hospital or nursing home.

Apart from submitting that patients could not be classified as consumers under the Consumer Protection Act, the Medical Association argued the following points that are briefly reproduced:

a) Deficiency in service, as defined under the Act, means any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance which is required to be maintained under any law or has been undertaken to be performed by a person in pursuance of a contract or otherwise in respect to any service.[8] Thus, deficiency is ascertained on the basis of certain norms relating to quality, nature and manner of performance, and since medical services cannot be judged on the basis of any fixed norms, therefore, practitioners are not covered under the definition of 'services'.

b) Only such persons can fairly and justly decide on medical malpractice cases who are themselves qualified in medical field as they will be able to appreciate the complex issues involved in such cases. The District Forum comprises of President who is or was a District Judge and the other two members who shall be persons having adequate knowledge or experience of, or having shown capacity in dealing with, problems relating to economics, law, commerce, accountancy, industry, public affairs or administration. Similarly State Commission and National Commission comprise of two non-judicial members who are concerned with economics, law, commerce, accountancy, industry, public affairs or administration, while the President shall be a person who is or was a judge of a High Court and Supreme Court, respectively. It was submitted that as the members of the Forum are not qualified to deal with medical malpractice claims medical practitioners should be exempted from the ambit of the Act.

c) Medical malpractice claims involve complex issues that will require detailed examination of evidence, deposition of experts and witnesses. This is contrary to the purpose of summary proceedings involving trial by affidavits, which is to provide speedy results. Hence Consumer Forum should not adjudicate medical malpractice cases.

d) If the medical practitioners are brought within the purview of the Act, the consequences would be a huge increase in medical expenditure on account of insurance charges as well as tremendous increase in defensive medicine, that medical practitioners may refuse to attend to medical emergencies and their will be no safeguards against frivolous and vexatious complaints and consequent blackmail.

The Supreme Court, however, rejected all these arguments and held -

a) The Act defines 'consumer' as any person who *hires* or *avails* of any services for a *consideration* which has been paid or promised or partly paid and partly promised under any system of deferred payment and includes any *beneficiary* of such services other than the person who hires or avails of the services for the consideration paid or promised, or partly paid and partly promised, or under any system of deferred payment, when such services are availed of with the approval of the first mentioned person.[9]

'Service' means service of *any description* which is made available to *potential users and* includes the provision of facilities in connection with banking, financing, insurance, transport, processing, supply of electrical or other energy, boarding or lodging or both, housing construction, entertainment, amusement or the purveying of news or other information, but does not include rendering of any service *free of charge* or under a *contract of personal service.*

The Supreme Court observed that all services are included other than those that are provided for free or under a contract of service.

b) The next question was on what parameters of deficiency in services of medical practitioners,

[8] Section 2(1)(g)
[9] Section 2(1)(d)(ii)

hospitals or nursing homes should be ascertained. Section 14 enumerates the relief that can be granted for deficiency in service. Sub-section 1(d) provides compensation for any loss or injury suffered by a consumer due to negligence of the opposite party. A determination of deficiency in services has, therefore, to be made by applying the same test as is applied in an action for damages for negligence. The test is the standard of medical care a reasonable man possessing same skills and expertise would employ under same circumstances. A medical practitioner need not exhibit extraordinary skills.

c) As regards the expertise of the member of the consumer forum to adjudicate on medical malpractice cases the Supreme Court observed that the object of the Act is to have members who have required knowledge and experience in dealing with problems relating to various fields connected with the object and purpose of the Act, which is to protect the interest of the consumers. Also as person who is well versed in law and has considerable judicial or legal experience heads all the forum, it will ensure that the deliberation on cases will be guided by legal principles. To say that the members must have adequate knowledge or experience in the field to which the complaints are related would lead to impossible situation. If the jurisdiction is limited to the area of expertise of its members then complaints relating to large number of areas will be outside the scope of the Act as the two members in the District Forum have experience in two fields. The problem will arise vertically as at particular times in State Commission there may be members having experience in fields other than that of members of District Forum, would this imply that the State Commission will be ousted of its Appellate jurisdiction in such complaints. The intention of the legislature is to ensure that the members have the aptitude to deal with consumer problems. It is for the parties to place the necessary material before the forum to deliberate upon. It cannot therefore, be said that since the members of the Consumer Dispute Redressal Agencies do not possess knowledge and experience in medicine, they are incapable of dealing with medical malpractice cases.

d) The Appellant had contended that medical malpractice cases involved complicated question of facts that are not fit for summary trials. Such cases should be kept outside the purview of the Act. The Supreme Court observed that in some cases complicated questions requiring recording of evidence of experts may arise but this was not so in all cases. There are many cases where the deficiency of services is due to obvious faults, as for instance, removal of the wrong limb or performance of an operation on the wrong patient or injecting drug to which the patient is allergic without looking into the out-patient card or the use of wrong anesthetic or during surgery leaving swabs or other foreign objects inside the patient during surgery. Such issues arising in complaint can be easily established and speedily disposed off by consumer courts. In complaints involving complicated question of facts that require recording of evidence of experts, the consumer forum can ask the complainant to approach a civil court for appropriate relief. The Act clearly states that its provision is in addition to and not in derogation of the provisions of any law for the time being in force.

e) The Supreme Court drew the following conclusions:

i) Services rendered to patient by a medical practitioner (except where the service is free of charge to every patient or under a contract of personal service), by way of consultation, diagnosis and treatment, both medical and surgical, would fall within the ambit of services as defined in Section 2(1)(o) of the Act

ii) The fact that medical practitioners belong to the medical profession and are subject to the disciplinary control of the Medical Council of India and /or State medical Councils would not exclude the services rendered by them from the ambit of the Act.

iii) Services rendered by a medical officer to his employer under the contract of employment is not 'service' under S. 2(1)(o) for purposes of the Act

iv) Services rendered at private or a Government hospitals, nursing homes, health centres and dispensaries for a fee are 'services' under the Act while services rendered free of charge are

exempted. Payment of a token amount for purposes of registration will not alter the nature of services provided for free. Services rendered at Government or a private hospitals, nursing homes, health centres and dispensaries where services are rendered on payment of charges to those who can afford and free to those who cannot are also 'services' for the purposes of the Act. Hence in such cases the person who are rendered free services are 'beneficiaries' under S. 2(1) (d) thereby 'consumer' under the Act.

v) Services rendered free of charge by a medical practitioner attached to a hospital/ nursing home or where he is employed in a hospital/ nursing home that provides free medical facilities, are not 'services' under the Act.

vi) Where an insurance company pays, under the insurance policy, for consultation, diagnosis and medical treatment of the insurer then such an insurer is a consumer under S. 291)(d) and services rendered either by the hospital or the medical practitioner is 'service' under S. 2(1)(o). Similarly where an employer bears the expenses of medical treatment of its employee, the employee is a consumer under the Act.

The remedy under Consumer Protection Act is in addition to civil remedy and it cannot be denied to a consumer merely on the ground that either the facts are too complicated or the complainant's claim is unreasonable.

In **Charan Singh vs. Healing Touch Hospital,**[10] the Appellant had brought a claim of Rs. 34 lakh for removal of one of his kidneys without his consent during the course of the operation, which resulted in the loss of his job and huge expenses for his treatment and upkeep. The National Consumer Commission dismissed his complaint on the reasoning that his claim was excessive, exaggerated and unrealistic. This was because a consumer is required to approach the District, State or National Commission directly depending on the compensation claimed.

> ...the complainant was drawing a salary of Rs. 3000 plus allowances...This is his allegation, which is not admitted by the opposite party. Even if we accept his contention is correct and even if we accept that as a result of wrong treatment given in the Hospital he has suffered permanent disability, the claim of Rs. 34 lakhs made by the complainant is excessive. We are of the view that this exaggerated claim has been made only for the purpose of invoking the jurisdiction of this commission... .

The Supreme Court opined that the quantum of compensation is at the discretion of the Forum irrespective of the claim. The legislative intent behind the Act is to provide speedy summary trial and the Commission should have taken the complaint to its logical conclusion by asking the parties to adduce evidence and rendered its findings on merits. The Court further held,

a. While quantifying damages, Consumer Forums are required to make an attempt to serve the ends of justice so that compensation is awarded, in an established case, which not only serves the purpose of recompensating the individual, but which also at the same time aims to bring about a qualitative change in the attitude of the service provider.
b. It is not merely the alleged harm or mental pain, agony or physical discomfort, loss of salary and emoluments etc. suffered by the Appellant which is in issue here. It is also the quality of conduct committed by the Respondents upon which attention is required to be founded in a case of proven negligence. (para 13, p. 673)

In the case of **Dr. J.J. Merchant vs. Shrinath Chaturvedi,**[11] the Supreme Court observed that in matters involving complicated questions of fact that require recording of evidence, the consumer forum has the discretionary power to direct the complainant to approach civil court for appropriate reliefs. Nevertheless, the procedure provided in the Act is adequate vis-à-vis civil suit to decide medical

[10] (2000) 7 SCC 668
[11] Dr. JJ Merchant v. Shrinath Chaturvedi (2002) 6 SCC 635

malpractice cases involving complicated questions of law and fact. For instance affidavits of experts including doctors can be taken as evidence. Thereafter, if cross-examination is sought by the other side and the Commission finds it proper, it can easily evolve a procedure permitting a party who intends to cross-examination to put certain questions in writing and experts including by doctors on affidavit could reply to those questions. In case where the stakes were high and if a party insisted on cross-examining such doctors or experts, there could be video or telephonic conference and at the initial stage this cost should be borne by the person who demands such conferences. Further, the Commissioner appointed at the work place can undertake the cross-examination. For avoiding delay the district forum or commissions can evolve a procedure of levying heavy cost where a party seeks adjournment on one or the other ground.

In **Spring Meadows Hospital vs. Harjo Ahluwalia**[12] the Supreme Court was concerned with the rights of a parent when a child dies due to medical negligence. It was argued by the hospital that the parents were not consumers under the Act so could not get any relief. The Court rejected this argument and observed that even parents were covered under the Act and there was nothing in the law which prevented the parents as well as the child from recovering damages. In this case, a child patient was treated for seven days in the Spring Meadows Hospital (Noida) for typhoid. The consultant physician prescribed "Chioromphenical injection", but the unqualified nurse misread it as "chloroquine" and indented, for the purchase of injection, "Lariago" (i.e. chloroquine). She injected chloroquine 5 mg IV, which was at least 3-1/2 times of the normal paediatric dose. The patient suffered irreversible brain damage. Treatment for 21 days in AIIMS, New Delhi, did not help. The patient was compelled to live in a vegetative state.

The National Consumer Commission, whose judgment was confirmed by the Supreme Court, came to the conclusion, that the attending doctor was negligent, as he allowed an unqualified nurse to administer the injection, even though the consultant doctor had advised administration by the attending doctor himself.

The hospital and the nurse were jointly and severally liable. The Court made the following important observations:

> Very often in a claim for compensation arising out of medical negligence a plea is taken that it is a case of bona fide mistake which under certain circumstances may be excusable, but a mistake which may tantamount to negligence cannot be pardoned....Gross medical mistake will always result in a finding of negligence. Use of wrong drug or wrong gas during the course of anesthetia will frequently lead to the imposition of liability.... Even delegation of responsibility to another may amount to negligence in certain circumstances. A consultant could be negligent where he delegates the responsibility to his junior with the knowledge that the junior was incapable of performing his duties properly.

The Court ordered the following compensation in the case:

(a) Rs. 12.5 lakhs to the child (Rs. 10 lakhs compensation, plus Rs. 2.5 lakhs for equipment).
(b) Rs. 5 lakhs to the parents, for mental agony.

The Supreme Court further held that when a young child is taken to a hospital and treated by the hospital, then

(a) the child's parents would come within the definition of "consumer"; and
(b) the child also becomes a "consumer", being a beneficiary of such services.

[Even where the patient is a married daughter, the parents who are required "to spend for her treatment, are also 'consumers'", **Rajaram S.Parale vs. Dr. Kalpana Desai**[13]]

---

[12] (1998) 4 SCC 39
[13] 1998 3 CPR 398 (BOM)

In the case of **Sailesh Munja vs. All India Institute of Medical Sciences (AIIMS)**,[14] the hospital claimed that since the treatment was subsidized by the hospital it would not be covered under the Act. The National Commission rejected this argument and held since the treatment was subsidized and not totally free; the hospital would be covered under the Consumer Protection Act.

In **Ranjit Kumar Das vs. ESI Hospital**[15] the Complainant's wife was not given admission to ESI Hospital though the Complainant was registered under the Act. She died and the Complainant was ordered to be paid Rs. 2 lakh as compensation. This case is significant because it lays down that the ESI hospitals, though government run, are covered under the Consumer Protection Act.

In **Suhas Haldulkar vs. Secretary, Public Health Dept., State of Maharashtra**[16] the National Commission held that since the hospital concerned was a Government hospital where patients are treated wholly without charge, a complaint before the Consumer Forum was not maintainable. The Complaint was dismissed since all the patients were treated free of charge but with liberty to the Complainant to approach the civil court. If of course some of the patients were being charged for the services provided, the Court would have had the jurisdiction even if the concerned patient was treated free of charge.

Can the consumer court go into the propriety of the fees charged by a doctor or a hospital?

In **B.S. Hegde vs. Dr. Sudhanshu Bhattacharya**[17] , the State Commission of Maharashtra held the doctor guilty of gross negligence for failure to render necessary post-operative care which was undertaken by him for a consideration (fee). This fee of Rs. 40,000 was paid by cheque a few days after the open-heart by-pass operation performed on the complainant at the Bombay Hospital, for rendering post-operative care and treatment for a period of three months. The fee was held to be excessive, unreasonable and unjustifiable though it was conceded that the amount to be charged as fee for medical services was the choice of the medical practitioner. The state commission awarded a sum of Rs. 2 lakh by way of compensation to the patient. The Complainant approached the Consumer Forum against exorbitant charges levied by the Respondent Cardiologist. Though the National Forum expressed its shock at the charges leveled, it held that it did not have the jurisdiction to go into the propriety of the fees charged by a doctor.

Civil Negligence and Deficiency in Medical Service

The substantial aspects of civil liability in negligence cases have, by and large, remained the same over decades with a few additions. The Indian civil law on negligence essentially is the judge-made common law followed in England for centuries. The main principles have been as laid out in the introduction to this chapter. This section looks at the application of these principles in concrete situations.

What are the duties of the doctor towards a patient who approaches him?

In **Dr. Laxman Balkrishna Joshi vs. Dr. Trimbak Bapu Godbole**[18] the patient had died due to shock when the Appellant attempted a reduction of fracture without taking elementary caution of giving anesthesia. In the light of the surrounding circumstances it was held that the Appellant was negligent in applying too much of force in aligning the bone. The Supreme Court held that doctors have the discretion to choose the course of treatment to be given and such discretion is relatively large in an emergency case. Nevertheless, the doctor owes his patients a duty of care in deciding whether to undertake the case, the line of treatment to be adopted and a duty in administering that treatment. When a doctor gives medical advice and treatment, he impliedly undertakes that he is possessed of skill and

[14] 2004 3 CPR 27 (NC)
[15] 1998 1 CPR 165 (Cal)
[16] 1994 3 CPJ 89
[17] II (1992) CPJ 449
[18] AIR 1969 SC 128

knowledge for the purpose. And in executing his duty he must employ a reasonable degree of skill, knowledge and care.

The Supreme Court also cited with approval the observations in Halsbury Laws of England in its Vol. 30 which state that whether or not he is a registered medical practitioner, such a person who is consulted by a patient owes him certain duties, namely

a) duty of care in deciding whether to undertake the case;
b) duty of care in deciding what treatment to give;
c) duty of care in his administration of that treatment; and
d) Duty of care in answering a question put to him by a patient in circumstances in which he knows that the patient intents to rely on his answer.

A breach of any of these duties will support an action for negligence by the patient.[19]

What does a complainant have to prove in order to carry home a charge of medical negligence? The Bombay High Court held that in a claim against medical negligence it was not sufficient to show that the patient suffered in some way. It had to be proven that the suffering or death of the patient was the result of negligence on the part of the doctor. In **Philips India Ltd. vs. Kunju Punnu**[20] the Bombay High Court held that in an action for negligence against a doctor, the plaintiff has to prove:

a) that the defendant had a duty to take reasonable care towards the plaintiff to avoid the damage complained of ;
b) that there was a breach of duty on the part of the defendant; and
c) That the breach of duty was the real cause of the damage complained of and such damage was reasonably foreseeable.

In the instant case the deceased was an employee of the Appellant. He approached the resident doctor of the company complaining of a digestive problem and was treated accordingly. After a week he returned, this time complaining of fever, cold and headache. Within four or five days he was brought in with high fever and was kept in the company's dispensary for observation. In the evening when the doctor found red pigmentation on his body he advised pathological tests and was taken to a nursing home of a specialist who treated him for bacteraemia. He approved of the treatment given by the doctor. Later it was discovered that the deceased was suffering from small pox that eventually caused his death.

The issue before the court was whether the doctor was negligent as he failed to diagnose small pox. The court held that a mistaken diagnosis was not necessarily negligent diagnosis. A practitioner can be liable if his diagnosis is so palpably wrong as to prove negligence, in other words, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part regard being had to the ordinary levels of skills in the profession. In the instant case there was no evidence to show that when the patient was taken to the company doctor any doctor of ordinary skill and competence could have diagnosed the disease of the patient as small pox or treated him for small pox. There was no epidemic of small pox at that time to induce the defendant doctor from carrying on test for the same. On the other hand, expert evidence showed that fulminating small pox could have occurred within 24 or 36 hours with no outward manifestations at all and that appearances were very indefinite with no findings on which to base a certain diagnosis. Thus, the defendant doctor was held to be not negligent. However, what is most important about this case is that the court held that just because a doctor is employed by a company to treat its employees, his responsibility is neither higher nor lower than that of an ordinary doctor.

In some circumstances, however, negligence may be attributed to a medical practitioner without proof of direct nexus between injury and conduct of the practitioner. In **Poonam Verma vs. Ashwin Patel**[21] Respondent No. 1 was a registered

[19] Vol. 30 Fourth Edition, p.31 para 34
[20] 1975 M. L.J. 792
[21] (1996) 4 SCC 332

homeopathy doctor who prescribed allopathic medicine for viral fever, which were prevalent in the Appellant's locality. The condition of the Appellant's husband deteriorated and he was admitted in Respondent No.2, a nursing home, for pathological tests and diagnosis. The deceased was treated for two days and as his condition did not improve he was shifted to another hospital where he died within hours of admission. In appeal the Supreme Court set up an ad hoc medical board to determine the cause of death. The board concluded that it was impossible to determine the true cause of the death. Therefore, claims against Respondent No.2 hospital were set aside but Respondent No.1 was held negligent on the ground that he was a homeopathic doctor and was not qualified to administer any other system of medicine. Respondent No.1 was held to be negligent per se.

Black's Law Dictionary defines 'negligence per se' as-

> Conduct, whether of action or omission, which may be declared and treated as negligence without any argument or proof as to the particular surrounding circumstances, either because it is in violation of a statute or valid municipal ordinance, or because it is so palpably opposed to the dictates of common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule, the violation of a public duty, enjoined by law for the protection of person or property, so constituted.

Also known as the Doctrine of *Res ipsa Loquitur* (things speaks for itself), the doctrine is attracted "...when an unexplained accident occurs from a thing under the control of the defendant, and medical or other expert evidence shows that such accidents would not happen if proper care were used, there is at least evidence of negligence 'for a jury'".[22]

It may be mentioned that now under the judgment in the Jacob Mathew's case (ibid) the Supreme Court has held that the doctrine of *res ipsa loquitur* is not applicable in criminal cases. It continues to be applicable in civil cases.

Even so, the present judgment seems to be incorrect, in the context of the long line of precedents on negligence. In this case, the cause of death was not attributed to the treatment. Thus there was no causal link established between the treatment and the death. In the absence of this, punishing a doctor for negligence does not fit within the law. The Court could have, of course, directed the homeopathic doctor to be prosecuted and his registration to be cancelled for practising allopathic medicine. The Court could also have directed the doctor to pay a fine which could then have been ordered to have been paid to the heirs of the deceased. But having come to the conclusion that there was no causal link between treatment and injury (in this case death) the doctor could not have been punished for negligence.

In **Shyam Sunder vs. State of Rajasthan,**[23] the doctrine of *res ipsa loquitur* was again discussed. The normal rule is that it is for the plaintiff to prove negligence, but, in some cases, considerable hardship is caused to the plaintiff, as the true cause of the accident is not known to him, but is solely within the knowledge of the defendant who caused it. The plaintiff can prove the accident but cannot prove how it happened (so as) to establish negligence on the part of the defendant. This hardship is sought to be avoided, in certain cases, by invoking the principle of *res ipsa loquitur*, where the thing is shown to be under the management of the defendant or his servants, and the accident is such, as, in the ordinary course of things, does not happen if those who have the management use proper care, then it affords reasonable evidence, in the absence of an explanation by the defendant, that the accident arose from want of care.

In **Jasbir Kaur vs. State of Punjab**[24] the Petitioner's newborn child's eye was gouged out by a cat that crept into the ward. The infant was kept in a separate room under the charge of the

---

[22] Street on Torts (1983) 7th Ed.
[23] AIR 74 SC 876
[24] AIR 1995 P&H 278

Petitioner's relatives, as there was a shortage of cots. It was contended by the Respondent Government hospital that the incident took place because of the Petitioner's relative's negligence in leaving the child alone. The Court applied the doctrine of *res ipsa loquitur* and held the hospital and State negligent. The safety and protection was under the control of the hospital and such an incident would have not have occurred in the ordinary course of things but did so, only because of the negligence of the hospital.

What happens when there is a difference of opinion amongst experts concerning the line of treatment to be adopted? In **Vinitha Ashok vs. Lakshmi Hospital**[25] the Appellant's uterus was removed because of excessive bleeding during a surgery for termination of pregnancy that was discovered to be cervical pregnancy. The Appellant alleged that had a sonography been performed the nature of the pregnancy would have been determined and she would not have had her uterus removed. The Supreme Court observed that there was a difference of opinion among medical experts on whether ultra sonography could determine cervical pregnancy. The Appellant showed no symptoms of cervical pregnancy and there was no reason for the Respondent doctor to suspect that and resort to a different course of treatment. In Kerela removal of uterus was recommended for tackling excessive bleeding in case of cervical pregnancy, and in the instant case the Respondent had to resort to it to save the Appellant's life. The Supreme Court, thus, held that the course adopted by the Respondent doctor was reasonable and although the risk involved might have called for further investigation, the Respondent doctor's view could not be dismissed as being illogical. A difference of opinion amongst experts on procedure adopted by a doctor cannot be called negligence if the procedure adopted is commonly in practice in an area.

A totally free treatment in a place which gives free treatment to everybody may not entitle the complainant to approach the Consumer Court. But he would still be entitled to approach the District Court by filing a suit for damages. In **S. Mittal vs. State of U.P.**[26] the Court was concerned with negligence in eye camps. An eye camp was organised for extending expert ophthalmic surgical treatment to patients of a particular place in Uttar Pradesh. The operated eyes of several patients were, however, irreversibly damaged, owing to post-operative infection of the "intra ocular cavities of the eyes", caused by normal saline used at the time of surgery. A public interest litigation was filed, praying (apart from other relief) for compensation to victims for negligence in the arranging of the eye operations. The Supreme Court directed the State Government to pay Rs. 12,500 compensation to each victim (in addition to Rs.5, 000 already paid). The Supreme Court observed that (a) It was no defence, that the treatment was gratuitous or free. (b) The State Government would be liable for negligence in such activities.

In **Eby Minor vs. GEM Hospital,**[27] a newborn child developed gangrene because of which his hand below the elbow had to be amputated. He was a new born premature child placed in an incubator in the Respondent hospital. The National Commission found that there could have been no cause for gangrene except infection which could only have been contacted due to the negligence of the hospital. A compensation of Rs. 1, 00,000 was awarded.

Does the non-conduct of necessary pre-operative tests amount to negligence? This was the issue before the National Commission in **Dr. Kaligoundon vs. N. Thangamuthu**.[28] The Complainant's wife had gynecological problems in terms of excessive bleeding. She was operated upon and her uterus removed. After this, she complained of giddiness and vomiting and died. The death certificate gave the cause of death as renal failure and septicaemia. The National Commission found the doctor guilty of negligence on the ground that despite there being no urgency in undertaking the surgery no tests were conducted prior to the surgery to assess renal functioning.

---

[25] (2001) 8 SCC 731
[26] (1989) 3 SCC 223
[27] 2004 3 CPJ 37
[28] 2004 3 CPJ 29 (NC)

Similarly, in **S.V. Panchori vs. Dr. Kaushal Pandey**[29] the Commission held that omission to do a routine investigation constitutes deficiency in service.

The other issue which the Courts have been concerned with relates to the use of medical literature in dealing with medical negligence cases. Can such literature be used to prove or disprove the findings of negligence? In **P.Venkatalaxmi vs. Dr. Y. Savitha Devi**[30] the National Commission observed that the ground reality was that rarely did doctors testify against doctors and therefore there was nothing wrong in using medical literature for determining a case.

Can a hospital be held guilty of negligence if it does not have adequate infrastructure? In **T. Vani Devi vs. Tugutla Laxmi Reddy,**[31] the Complainant's wife died in the nursing home where she was admitted for delivery. When she started bleeding no proper care was taken. The National Commission found that the nursing home was not equipped to deal with emergencies nor it had any arrangements to deal with emergencies and as such was guilty of negligence. The Consumer Forum has, however, held that if beds are not available in a hospital, refusing admission to the patient does not amount to deficiency in service. In **Bhajan Lal Gupta vs. Mool Chand Kharati Ram Hospital**[32] when the patient was refused admission and asked to go to another hospital due to non-availability of beds, the National Forum held that this did not amount to deficiency in service.

The issue of informed consent has been much litigated in foreign jurisdictions. The National Commission was confronted with this issue in the case of **Dr. P.S. Hardia vs. Kedarnath Sethia**[33]. The Complainant lost his eye due to a surgery which was not an emergency surgery. The Court found the doctor negligent on the basis that performed an operation which was totally unnecessary and also held that simply taking signature on a form stating "to treat him at his own risk under expressive consent" did not absolve the doctor from taking a more detailed and direct consent especially when there was no emergency.

Is a doctor responsible for the negligence of his nurse? In **K.G.Krishnan vs. Praveen Kumar (minor),**[34] the minor was admitted to a hospital with fever. He was given a paracetomal injection by the nurse in such a way that his right side was paralysed. The nurse was not joined as a party to the case but the National Commission held that the nurse was the employee of the doctor and as such the doctor was vicariously liable for her negligence and directed the doctor to pay compensation of Rs. 1 lakh.

Is a hospital liable for the negligence of its doctors? In **Savita Garg vs. Director, National Heart Institute**[35] the Appellant's husband was admitted to the National Heart Institute and according to the Appellant her husband died due to negligence of doctors and nurses treating him. The National Forum dismissed her case as she had not joined the treating doctors and nurses as parties to the case. She approached the Supreme Court. The Supreme Court, in this landmark decision held the following:

- It was not necessary to join the treating doctors or nurses as parties as long as the hospital was made a party;
- Only the initial burden of proving negligence is on the Complainant. After this, it would be for the hospital to show from records, etc. as to what care and treatment were given. It is for the hospital to satisfy that there was no lack of care or diligence.
- The hospital is responsible for the acts of their permanent staff as well as staff whose services are temporarily requisitioned for the treatment of patients.

---

[29] 1999 1 CPJ 332
[30] 2004 2 CPJ 14 (NC)
[31] 2003 1 CPJ 180
[32] 2001 1 CPR 70
[33] 2004 3 CPJ 19 (NC)
[34] 2003 2 CPJ 125
[35] (2004) 8 SCC 56

The Supreme Court remitted the case back to the National Forum for trying it on merits.

Does the failure to monitor dosage of drugs amount to negligence? In **Mohd. Ishfaq vs. Dr. Martin D'souza**[36], the patient was put on haemodialysis and was asked to undergo a kidney transplant. He was administered amicacin 500 mg injections twice a day for 10 days at the end of which he lost his hearing totally. The National Commission held that it was the responsibility of the hospital to monitor the patient and modify the dosage as per the available literature and failure to do so amounted to negligence. The patient was ordered to be paid Rs. 4 lakh as compensation for treatment and Rs. 2 lakh towards the mental agony suffered by him.

Can a doctor charge for facilities he does not offer? In **R.M. Joshi vs. Dr. P.B. Tahilramani**[37] the State Commission ordered the recovery of bed charges when the patient was made to sleep on a table amounted to deficiency in service.

Can a doctor be charged for performing a surgery, which is not necessary? In **Uttaranchal Forest Hospital Trust vs. Smt. Raisan**[38] the complainant's organ was removed. When the organ was sent for diagnosis no cancer was found. The State Commission found the doctor guilty of negligence for performing a surgery that was wholly unnecessary.

Does the failure of a procedure undertaken by a doctor imply that he was negligent? The Supreme Court has categorically said no. In **State of Punjab vs. Shiv Ram**[39] the Supreme Court was dealing with a case where sterilization had failed and the woman gave birth to a child. This was in a State hospital. The State argued that there was always a small chance of failure in such procedures and the failure of sterilization did not mean that the doctor was negligent. The Supreme Court upheld this argument and cited with approval a decision of the English Court in **Eyre vs. Measday**[40] in which the Court had observed:

> In the absence of any express warranty, the Court should be slow to imply against a medical man an unqualified warranty as to the results of an intended operation, for the very simple reason that, objectively speaking, it is most unlikely that a responsible medical man would give a warranty of this nature.

Conclusion

Cases of medical negligence are rising rapidly especially in the consumer courts. However getting fellow doctors to testify even in cases which are self evident is a very difficult task. With the recent decisions of the Supreme Court in matters concerning criminal negligence, it is going to be even more difficult for doctors to be prosecuted under the criminal law.

Though no such reliable standard has emerged by which a physician can avoid liability with certainty, there are precautions that a physician can take to ensure that the information provided to the patient falls within the ambit of informed consent. In India, this duty has to be fulfilled with even more care due to level of illiteracy, and poor medical awareness amongst the population even among the urban educated classes. It is the duty of the doctor to explain the method of treatment and the risks involved in a language and manner that the patient can understand .Merely paying lip service to the law does not absolve the doctor of his duties in this regard. The very fact that the patient visits doctor establishes a relationship in which doctor has the duty of disclosure. As in cases of negligence, no uniform standard can emerge, as a practice of medicine is extremely case specific. Doctors are trusted to exercise this discretion in the interest of the patient under the exception for

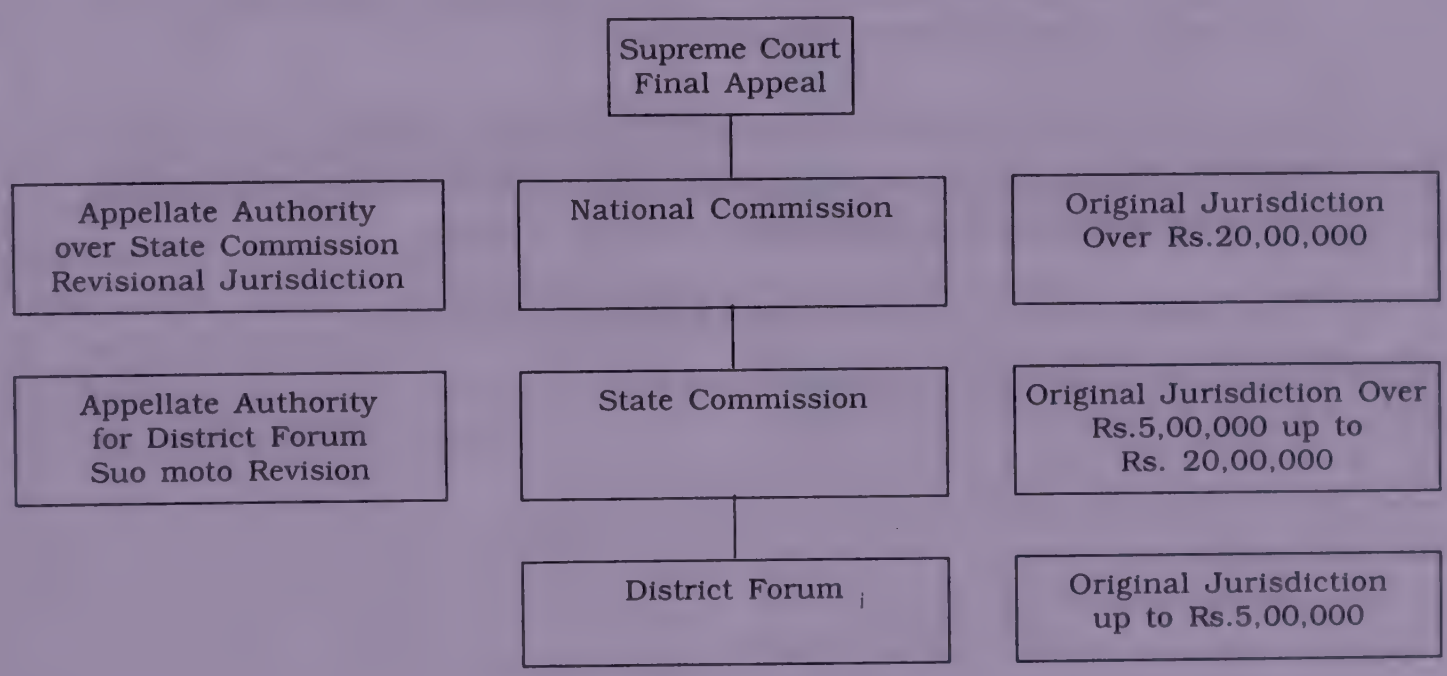
---

[36] 2002 2 CPR 151
[37] 1993 3 CPR 435 (Bom)
[38] 2004 1 CPJ 257
[39] (2005) 7 SCC 1
[40] 1986 1 ALL ER 488

therapeutic privilege. The standard of what constitutes informed consent itself being so ambiguous it is even more abstract in the light of such an exception. To determine how much information should be divulged to the patient the mental state of the patient at that point of time is crucial. Therefore, courts have to examine the circumstances surrounding the treatment of the patient before drawing conclusions .The question that also arises is what is the level of informed consent if there was only one possible course of treatment and the chances of survival are low? In such a case informed consent may even assume more importance as the risk to the patient increases.

What constitutes 'informed consent' is yet to be settled, though a number of cases concerning informed consent have been coming up in the courts Majority of the successful cases have been those where the Courts are not required to go into complicated medical evidence. They have repeatedly held that a doctor is liable only if the line of treatment prescribed by him was not a recognized method altogether. Many cases have been rejected by the Courts on the basis that medical experts had not testified in support of the Complainants. While it is not essential that medical experts testify in all cases, this becomes important in complex medical negligence cases. Even now, it is difficult to get doctors to testify against their brethren and this will be an important task to be taken up in the next few years. Also, by and large the Medical Councils' performance in cases pertaining to medical negligence requires much to be desired but it is a remedy which should not be ignored.

Structure of Consumer Forums / Commissions and their Jurisdictions



The maximum time limit for a claim to be filed under CPA is 2 years from the date of occurrence of the cause of action. There is no court fee to be paid to file a complaint in a Consumer Forum / Commission. Further, a complainant/opposite party can present his case on his own without the help of a lawyer.

As per the Consumer Protection Rules, 1987, a complaint filed in the Consumer Forum / Commission shall be adjudicated, within a period of 90 days from the date of notice by opposite party and within 150 days if it requires analysis or testing of commodities

PATIENT'S RIGHTS

1. You have a right to be told all the facts about your illness; to have your medical records explained to you; and to be made aware of risks and side effects, if any, of the treatment prescribed for you do not hesitate to question your doctor about any of these aspects.

2. When you are being given a physical examination, you have a right to be handled with consideration and due regard for your modesty.

3. You have a right to know your doctor's qualifications. If you cannot evaluate them yourself, do not hesitate to ask someone who can.

4. You have a right to complete confidentiality regarding your illness.

5. If you are doubtful about the treatment prescribed and especially an operation suggested, you have a right to get a second opinion from any specialist.

6. You have a right to be told in advance, what an operation is for and the possible risks involved. If this is not possible because of your being unconscious or for some other reasons, your nearest relatives must be told before they consent to the operation.

7. If you are to be discharged or moved to another hospital, you have a right to be informed in advance and to make your own choice of hospital or nursing home, in consultation with the doctor.

8. You have a right to get your case papers upon request.

Seven

Drugs and Public Health

Adv. Mihir Desai and Adv. Dipti Chand

Introduction

In this Chapter we address the following questions:

- To what extent do the Indian laws deal with provision of cheap and accessible medicines?
- What are the legal controls against spurious, substandard and misbranded drugs?
- What kind of legal control is exercised over misleading and false advertisements relating to effect of drugs and cure of ailments?

Access to cheap drugs is an essential aspect of right to healthcare. The major laws and orders governing these areas are the following:

1. Drugs and Cosmetics Act, 1940
2. Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954
3. Patents Act, 1970
4. Drugs Price (Control) Order, 1995

Other than these, the Pharmacy Act requires that only a registered pharmacist may prepare and compound drugs. The expectation from the legislation and executive would be that cheap, effective, sufficient and high quality drugs are available to the people at large.

Affordable drugs are an integral component of universal health care and accessible health care. Drugs need to be easily available and of good quality, and should neither be spurious nor damaged. They should be able to achieve what they claim to do. Public hospitals are responsible for providing free or subsidized drugs to patients. But the State has been moving away from its responsibility, reducing investment in healthcare and consequently, on drugs, increasing user charges, and so on.

The major purpose of enacting the Drugs and Cosmetics Act, 1940 was to ensure quality of drugs and prevent sub standard drugs from flooding the markets. Apart from this are the Patents Act and its recent amendments that increasingly play an important part in making the right to health substantial for the people. The Drugs and Cosmetics Act regulates the quality of drugs, its manufacture, distribution and sale. It applies to all variety of drugs such as ayurvedic, unani, allopathic and homeopathic. The law also deals with cosmetics but in this chapter, we are not concerned with that aspect. Drugs can be imported, manufactured, stocked and sold only under certain strict conditions.

What is a drug? Are vitamin tablets drugs or diet supplements? Can cotton gauze be called a drug? Can condoms be classified as drugs? A large amount of litigation has accumulated on what constitutes drugs. If an article does not constitute a drug it can be manufactured, stocked and sold under highly relaxed conditions. So the attempt of the private sector has been to somehow get out of the purview of the law. However, under the Excise legislation the attempt of the private sector is to classify various items as medicaments as there is tax exemption.

The Drug Rules are very detailed. They spell out the medicines which can be given only on prescription and those that do not require prescription. The rules also specify when a particular drug will be treated as of standard quality. They provide for detailed instructions concerning manufacture, storage and sale. There are also detailed guidelines concerning the conduct

of clinical trials. Quality control in drugs is sought to be ensured through licensing and supervision procedures. A large number of judgments pertain to conditions of licensing and revocation of licenses.

Chapter IV of the Act deals with the manufacture, sale and distribution of drugs. Section 16 stipulates that for the purpose of the Chapter that the expression 'standard quality' in relation to a drug means that the drug should comply with the standard set out in Second Schedule. Section 17 of the Act defines 'misbranded drugs'; Section 17-A 'adulterated drugs'; and Section 17-B 'spurious drugs'.

Section 17. Misbranded Drug- for the purposes of this Chapter, a drug shall be deemed misbranded-

(a) If it is so coloured, coated, powdered or polished that damage is concealed or if it is made to appear of better or greater therapeutic value than it really is; or
(b) If it is not labeled in the prescribed manner; or
(c) If its label or container or anything accompanying the drug bears any statement, design or device which makes any false claim for the drug or which is false or misleading in any particular.

Section 17A. Adulterated Drugs- For the purpose of this Chapter, a drug shall be deemed to be adulterated-

(a) If it consists in whole or in part, of any filthy, putrid or decomposed substances; or
(b) If it has been prepared, packed or stored not under sanitary conditions whereby it may have been contaminated with filth or whereby it may have been rendered injurious to health; or
(c) If its container is composed, in whole or in part, of any poisonous or deleterious substances which may render the contents injurious to health; or
(d) If it bears or contains, for purposes of colouring only, a colour other than one which is prescribed; or
(e) If it contains any harmful or toxic substance which may render it injurious to health; or
(f) If any substance has been mixed there with so as to reduce its quality or strength.

Section 17B. Spurious Drugs- For the purposes of this Chapter, a drug shall be deemed to be spurious-

(a) If it is manufactured under a name which belongs to another drug; or
(b) If it is an imitation of, or is a substitute for, another drug or resembles another drug in a manner likely to deceive or bears upon it or upon its label or container the name of another drug unless it is plainly and conspicuously marked so as to reveal its true character and its lack of identity with such other drug; or
(c) If the label or container bears the name of an individual or company purporting to be the manufacture of the drug, which individual or company is fictitious or does not exist; or
(d) If it has been substituted wholly or in part by another drug or substance; or
(e) If it purports to be the product of manufacture of whom it is truly a product.

Section 18. Prohibition of manufacture and sale of certain drugs and cosmetics- From such date as may be fixed by the State Government by notification in the official Gazette in this behalf, no person shall by himself or by any other person on this behalf-

(a) Manufacture for sale or for distribution, or sell, or stock or exhibit or offer for sale, or distribute-
i) Any drug which is not of a standard quality, or is misbranded, adulterated or spurious;
ii) Any cosmetic which is not of a standard quality or is misbranded or spurious ;
iii) Any patent or proprietary medicine, unless there is displayed in the prescribed manner on the label or container thereof the true formula or list of active ingredients contained in it together with the quantities, thereof;
iv) Any drug which by means of any statement, design or device accompanying it or by any other means, purports or claims to prevent, cure or mitigate any such disease or ailment, or to have any such other effect as may be prescribed;
v) Any cosmetic containing any ingredient, which may render it unsafe or harmful for use under the directions, indicated or recommended

vi) Any drug or cosmetic in contravention of any provision of this Chapter or any rule made there under;

(b) Sell or stock or exhibit or offer for sale, distribute any drug or cosmetic which has been imported or manufactured in contravention of any of the provisions of this Act or any rule made there under;

(c) Manufacture for sale or for distribution, or sell, or stock or exhibit or offer for sale, or distribute any drug or cosmetic, except under, and in accordance with the condition with the conditions of, a licence issued for such purpose under this Chapter Provided that nothing in this section shall apply to the manufacture, subject to prescribed conditions, of small quantities of any drug for the purpose of examination, test or analysis:
Provided further that the Central Government may, after consultation with the Board, by notification in the Official Gazette, permit, subject to any conditions specified in the notification, the manufacture for sale or for distribution, sale stocking or exhibiting or offering for sale or distribution of any drug or class of drugs not being of standard quality.

Sections 20 and 21 contemplate the appointment of Government analysts and inspectors by the Central and State Government, respectively, to execute the purposes of the Act. Inspectors have various powers including that of inspection, taking samples of any drug and cosmetic, examination of any records, registers or documents et al, and search and seizure.

Section 27 prescribes the penalty for manufacture, sale etc., of any drug which is adulterated or spurious or any drug used by any person for or in the diagnosis or prevention of any disease or disorder, which is likely to cause death or is likely to cause such harm to the human body, which would amount to grievous hurt within the meaning of Section 320 IPC, punishable with imprisonment for a term which may extend up to a term of life and with fine.

The Act also prohibits anybody from claiming that certain diseases listed under the Act such as AIDS, diabetes, can be in a guaranteed way be prevented or cured by the use of a particular medicine.

This aspect is dealt with further under the Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954. This Act concerns what is known as 'magic remedy' i.e. flimsy claims about remedies for a diseases which is otherwise not curable or remedies which do not really fall into any known scientifically tested categories.

The Act specifies two kinds of offences: advertisement of drugs for diseases specified in the Act, or the rules, and advertisements that are misleading about the nature, cure and any other material particular of the drug so advertised.

Section 3: Prohibition of advertisement of certain drugs for treatment of certain diseases and disorder- Subject to the provisions of this Act, no person shall take 'any part in the publication of any advertisement' referring to any drug in terms which suggest or are calculated to lead to the use of that drug for-

(a) procurement of miscarriage in women or prevention of conception in women; or
(b) maintenance or improvement of the capacity of human beings for sexual pleasure; or
(c) correction of menstrual disorder in women; or
(d) diagnosis, cure, mitigation, treatment or prevention of any disease, disorder or condition specified in the Schedule, or any other disease, disorder or condition specified in the Schedule, or any other disease, disorder or condition (by whatsoever name called) which may be specified in the rules made under this Act:

Provided that no such rule shall be made except-

(i) in respect of any disease, disorder or condition which requires timely treatment in consultation with a registered medical practitioner or for which there are normally no accepted remedies, and
(ii) after consultation with the Drugs Technical Advisory Board constituted under the Drugs and Cosmetics Act, 1940 and, if the Central Government considers necessary, with such other persons having special knowledge or practical experience in respect of Ayurvedic or

Unani systems of medicines as that Government deems fit.[1]

Section 4: Prohibition of misleading advertisement relating to drugs- Subject to the provisions of this Act, no person shall take any part in the publication of any advertisement relating to a drug if the advertisement contains any matter which-

(a) directly or indirectly gives a false impression regarding the true character of the drug; or
(b) makes a false claim for the drug; or
(c) is otherwise false or misleading in any material particular.

The above two laws deal mainly with quality control and ensuring that gullible consumers are not taken for a ride.

The availability of affordable medicines has been sought to be ensured in the past through the Patents Act and Drug Price Control Orders. The Essential Commodities Act authorizes the Government to fix ceilings on prices even in the private sector. Under this Act, from time to time Drug Price Control Orders have been issued to keep prices of essential drugs under check. Those drugs which are not covered under this Order have no ceilings on their price. Unfortunately since the Indian Government zealously undertook the path of liberalisation and privatisation the Drug Price Control basket has progressively shrunk and many affordable drugs have been taken out of the purview of the order and in respect of many others prices have been allowed to spiral. A challenge to this is pending in the Supreme Court and the outcome is awaited.

The Indian Patents Act, 1970 ensured the availability of cheap generic drugs by adopting the process rather than product patent for medicines and further, having relaxed provisions regarding compulsory licensing and import substitution. Of course, since India signed the TRIPS Agreement the Patent Act has been amended to do away with a substantial number of these protections. Thus in future, newer generic drugs that are cheaper than the branded ones will become difficult to access. Of course, even under the TRIPS Agreement, coupled with further developments like the Doha Declaration, it is possible for the Government to ensure the availability of cheap drugs as it has been done in some other countries. But this does not look likely in the current context. The judiciary has traditionally refrained from interfering in price fixation matters of most kinds and it is not likely that challenging price fixation directly in courts will yield any results. But other methods such as challenging patents, proceeding under the right to health care, etc. may be better options in the courts.

Case Law

Definition of Drugs

Due to the stringent licensing, manufacturing, stocking and selling provisions pharmaceutical companies are always on the look out for getting their products exempted from the definition of drugs. It is in the interest of manufacturers to avoid obtaining such licenses as then anything can be sold without adhering to strict quality control norms. By and large, however, the courts have given a liberal meaning to the term 'drug' and not allowed easy escape routes for these companies.

Cadila Pharmaceuticals Ltd. vs. State of Kerala[2] dealt with the definition of the term drug. Many ingestible are given fancy names in order to claim that they are not 'drugs'. The Petitioner manufactured EC 350 (Vitamin E and C) capsules and Cecure (multi-vitamin capsules) that were sold in medical shops as 'dietary supplements'. The issue before the Court was whether vitamin capsules fall under the definition of 'drugs' under the Drugs and Cosmetics Act and therefore, required license.

Section 3(d) of the Act defines Drugs which definition includes-

(i) all medicines for internal or external use of human beings or animals and all substances intended to be used for or in the diagnosis,

[1] Section 5 applies to advertisement of magic remedies
[2] AIR 2002 Kerala 357

treatment, mitigation or prevention of any disease or disorder in human beings or animals, including preparations applied on human body for the purpose of repelling insects like mosquitoes;

(ii) such substances (other than food) intended to affect the structure or any function of the human body or intended to be used for the destruction of (vermin) or insects which cause disease in human beings or animals, as may be specified from time to time by the Central Government by notification in the Official Gazette;

(iii) all substances intended for use as components of a drug including empty gelatin capsules; and

(iv) Such devices intended for internal or external use in the diagnosis, treatment, mitigation or prevention of disease or disorder in human beings or animals, as may be specified from time to time by the Central Government by notification in the Official Gazette, after consultation with the Board.

The Petitioner contended that the vitamin capsules in question were for general well-being, and not a cure or prevention of any disease or disorder. Therefore, they did not fall within the definition of the term 'drugs' within the meaning of S.3 (d) (1).

The high court disagreed with the submission of the Petitioner that the two products in question were not part of any treatment of disease or disorder. It stated that the vitamin capsules in question were not used by any person as a general dietary supplement. In cases of vitamin deficiency doctors prescribe these vitamin capsules of a definite dosage, which mitigate or prevent diseases arising.. These vitamins capsules therefore squarely fall within the definition of 'drugs' under the Act.

Similarly, in **Chimanlal vs. State of Maharashtra**[3] the issue before the Supreme Court was whether 'absorbent cotton; wool, roller bandages and gauze' are drugs under the Act. The Supreme Court held that the definition of 'drugs' in S.3(d) of the Drugs Act is comprehensive enough to cover not only medicines but also substances intended to be used for or in treatment of diseases of human beings. 'Absorbent cotton, wool, roller bandages and gauze' are substances used for or in treatment of disease, and hence are 'drugs' for the purposes of the Act. The main object of the Act is to prevent sub-standard drugs, presumably for maintaining high standards of medical treatment. That would certainly be defeated if the necessary concomitants of medical or surgical treatment were allowed to be diluted.

In **Prabhudas Kalyanji Adhia vs. State of Maharashtra**[4] the Bombay High Court was concerned with a case where the Appellant was convicted of selling a substance which he described as D.D.T. Compound without a license. His contention was that though the compound did use D.D.T. it was not meant for medical use and this was also made clear on the label. The Court held him guilty by reasoning that while implementing laws meant for public benefit popular meaning should be given to words. Thus, to a common person D.D.T. is a drug and even if it is not meant to be used as medicine a license would be required.

While under the Drugs Act, there has been a consistent attempt on the part of the manufacturers to show that their product does not come within the definition of 'drug', under the Excise law the situation is virtually the reverse. Under Excise law, manufacturers of cosmetics are required to pay heavy excise duty while those who manufacture 'medicaments' are exempt from such duty or are charged very less. The constant attempt on the part of manufacturers has been to claim that their product is a 'medicament' and thus not subject to excise.

In a series of judgments the Supreme Court has laid down a twin test for determining whether an item falls within the term medicament or not.[5] The twin tests are as follows:

1. Whether the item is commonly understood as a medicament which is called the common parlance test. For this test it will have to be seen whether in common parlance the item is

[3] AIR 1963 SC 665
[4] AIR 1970 BOM 134
[5] CCE V. Richardson Hindustan Ltd. (2004) 9 SCC 136, Puma Ayurvedic Herbal (P) Ltd. v. CCE (2006) 3 SCC 266

accepted as a medicament. If a product falls in the category of medicament it will not be an item of common use. A user will use it only for treating a particular ailment and will stop its use after the ailment is cured. The approach of the consumer towards the product is very material. One may buy any of the soaps available in the market. But if one has a skin problem, he may have to buy a medicated soap. Such a soap will not be an ordinary cosmetic. It will be medicament falling in Chapter 30 of the Tariff Act.

2. In respect of ayurvedic medicaments, are the ingredients used in the product mentioned in the authoritative textbooks on ayurveda?

A large number of commonly known articles such Vicks Vaporub, anti dandruff shampoos, pain balms, prickly heat powders and some of the hair oils have been held to be medicaments by the Supreme Court on the basis of the twin test.

Spurious and Dangerous Drugs

There are many occasions when the Government totally bans the manufacture or sale of certain drugs. The question before the courts has been whether the Government can do so and further what is the scope of the Court's interference in such matters.

S.R. Pvt. Ltd vs. Prem Gupta, Drug Controller (India) New Delhi[6] was a case dealing with a ban on spurious drugs. The petition challenged the order of Central Government under S. 26-A of the Drugs and Cosmetics Act, 1940 which banned the manufacture and sale of fixed dose combination steroids.

Section 26-A of the Act empowers the Central Government to prohibit in public interest the manufacture, sale or distribution of any drug if it is satisfied that the use of such drug is likely to involve any risk to human beings or it does not have the therapeutic value claimed or purported to be claimed in it.

The Act provides for the constitution of 'Drugs Technical Advisory Board' to advice Central and State Government on any matter tending to secure uniformity throughout the country in the administration of the Act. The Board is to comprise of persons with expertise in drugs along with representatives from Central and State Government. The ban on fixed dose combinations of steroids was imposed after consultation with the Technical Advisory Board.

The issue before the high court was whether the Central Government had acted arbitrarily or the opinion tendered by the Board was arbitrary and without substance. The court held that the advice tendered by the Board consisting of experts, who have special knowledge and experience in respect of different kinds of drugs, and the opinion formed after due exchange of views in itself ensures that the opinion given by the Board has a rational basis and suffices for Central Government to issue notification in exercise of its power under S.26-A of the Act.

When such a high powered body consisting of experts arrives at such a decision after due consideration and exchange of views, we have to presume that the advice tendered is good in the absence of any basis to characterize it as arbitrary. In this case there is no material or basis to discard the opinion formed and the advice tendered by the Board. Therefore, as the Central Government has exercised its power under S. 26A of the Act on the advice tendered by the board, we are unable to agree that the impugned notification is illegal, arbitrary or violation of Articles 14 and 19(g) of the Constitution.

The court therefore concluded that it would not ordinarily interfere with a decision taken by the State acting on the recommendation of an expert body to prohibit a particular drug or combination. In **Systopic Laboratories Pvt. Ltd. vs. Dr. Prem Gupta & Ors.**[7] Various pharmaceutical companies had challenged a notification by the Government banning the manufacture and sale

[6] AIR 1993 P&H 28
[7] (1994) Supp 1 SCC 160

of corticosteroids with another drug for internal use for treatment of asthma under Section 26 A of the Drugs Act. Expert committees were set up by the Government that found that no theraupatic purpose would be served by such combinations. They went into the massive literature submitted by the Companies but still came to the same conclusion. They also felt that no purpose would be served by clinical trials. Accordingly, the expert committees recommended a total prohibition and the Government agreed with this. The Supreme Court found nothing wrong with such a prohibition and held that the Courts would not interfere in such matters when the Government has acted on the advice of expert committees.

A similar situation arose in **Laxmikant vs. Union of India**[8] where the Central Government, in exercise of its powers under Section 33EE of the Act, banned in public interest the manufacture and sale of all ayurvedic drugs licensed as toothpaste/ toothpowders containing tobacco.

The Appellant contended that they used only 4 per cent of tobacco and there was no conclusive evidence to show that such a minute quantity could pose a threat to health, and that even the members of the Advisory Board under the Act held divergent views on it. Such ban was arbitrary and violated their right to carry on trade.

The Supreme Court held that the Central Government in consultation with the Ayurvedic, Siddha and Unani Drugs Technical Advisory Board, an Expert Body constituted under Section 33D of the Act, had arrived at a conclusion that tobacco contained carcinogenic elements, and therefore, its use should be banned in toothpastes. A similar view was expressed at an international conference held at AIIMS, New Delhi in collaboration with WHO. Hence, the Court held that even though the ban offends the right to carry on trade, it is justified in public interest and falls under Article 19(6) of the Constitution being a reasonable restriction on the right to carry on trade or business.

In **Bharat Biotech International Ltd. vs. A.P. Health and Medical Housing and Infrastructure Development Corporation,**[9] a WHO pre-qualification was made an eligibility criterion for the tender for supply of Hepatitis-B drugs. This was challenged as arbitrary and with the intent to exclude competition in favour of one manufacturer. The high court evaluated the provisions of Drugs and Cosmetics Act to determine if it provided an efficient machinery to ensure standard quality of drugs or if WHO pre-qualification actually set higher standards, which would justify the impugned decision. The high court concluded that the State had failed to establish that WHO adopts standards that are higher than the standards adopted by Indian law for assessing the quality of the product. It held that the Indian laws were stringent in ensuring a high standard of drugs but has been futile because of laxity on part of State in enforcing the law. Instead of rectifying the implementation of the Act, the State cannot seek shelter in such a manner. Accordingly, such a prequalification was set aside.

In **Sidi Pharmacy Pvt. Ltd. vs. Union of India**[10] the Supreme Court was considering a case where upon the advice of an expert committee, the Government refused to grant license to a company that wanted to manufacture ayurvedic injectibles. The Court refused to interfere in the matter and held

> Whether to permit or not to permit Ayurvedic injections is a policy decision requiring serious thought and consideration to be given to people's health and treatment methods. We do not think that adjudication of such issues falls within the scope of judicial review and the jurisdiction of this Court.

The courts have especially refused to interfere in matters where the prohibition of manufacture or sale of drugs by the Government has been based on expert committee reports.

There have been two reported cases where an organization had applied to the Court seeking a

---

[8] (1997) 4 SCC 739
[9] AP HC dt. 10/12/2002
[10] (2004) 13 SCC 780

ban on the manufacture and sale of a drug. In the case of **AIDWA vs. Union of India**[11], a women's organization filed a Petition in the Supreme Court seeking a ban on the use of quinacrine in the form of pellets or otherwise as a method of sterilization. The Central Government filed an Affidavit stating that they were in the process of prohibiting the import, manufacture and sale of quinacrine for use a method of non surgical sterilization on women. In view of the Affidavit, the Supreme Court disposed of the Petition.

In **Vincent Panikulangara vs. Union of India**[12] the Public Interest Law Service Society, Cochin, filed a petition in the Supreme Court asking directions for banning import, manufacture, sale and distribution of such drugs as had been recommended for banning by Drugs Consultative Committee set up by the Government and also asked for the cancellation of licenses granted in respect of these drugs. The Society also asked for the setting up of a high powered committee to go into the hazards suffered by people due to these drugs and for the award of compensation to such persons.

The Supreme Court has held that the Courts were not the appropriate forum to decide about such issues that require expert opinions. The Court however expressed a hope that the Central Government would have the issues concerning banning of specific drugs referred to a special committee and deal with it expeditiously.

Though Vincent's petition did not yield the desired result, there was pressure on and in the government to ban more irrational and hazardous drugs. Four more categories were banned in 1984, and three more in 1988 including high does of E.P Combination.[13] By April 1992, a total 45 categories were banned by various gazette notifications, but brand names and even generic names were not publicized widely.[14]

AIDAN Case: Another public interest litigation was filed in the Supreme Court by the Drug Action Forum (DAF), Karnataka along with the All India Drug Action Network (AIDAN) in November 1993. The Supreme Court directed a ban on the manufacture of fixed dose combinations of Analgin known by any brand name. By March 1998, a few more drugs were taken up by DTAB for scrutiny and Baralgan was banned. A petition on the drug price control was filed by the AIDAN, the Medico Friends Circle (MFC), the Low Cost Standard Therapeutics (LOCOST) and the Jan Swasthya Sahyog in 2003. [15] This petition seeks to ensure that the medicines/drugs set out in the National Essential Medicines List 2003 are available at affordable prices for the poor by bringing all of them under price control. It is still pending in the apex court. The petition asks the government to:

- Ensure that the medicines/drugs set out in the National Essential Medicines List 2003 are available and at affordable prices for the poor by bringing all of them under price control.
- Quash the Pharmaceutical Policy 2002 to the extent to which this policy is incompatible with the other reliefs claimed in the petition.
- Bring all drugs and formulations under a system of monitoring of their prices and affordability with a view to ensuring that even drugs/medicines not on the National Essential Medicines List are available at reasonable prices.
- Ensure that only safe, rational drugs and formulations whose efficacy is scientifically proven, be permitted to be manufactured and marketed in India.
- Ban the manufacture, distribution and import and export of all irrational formulations which have no scientific validity, or violate the principles of rational therapeutics or which do not figure in internationally accepted pharmacoepia.
- Allow the manufacture and marketing of only those single-ingredient formulations that are referred to in pharmacology textbooks.

[11] (1998) 5 SCC 214
[12] (1987) 2 SCC 165
[13] Phadke Anant, *Drug Supply and Use: Towards a Rational Drug Policy*, pp.54
[14] ibid
[15] Writ Petition no. 423 of 2003 pending in the court

- Set up a National Drug Authority in accordance with the recommendations of the Drug Policy of 1986 and 1994.
- Ensure that both branded and generic medicines in the market are of standard quality and manufactured according to Good Manufacturing Policies (GMP) and Good Laboratory Practices (GLP).

- Ensure that all medicines needed for important public health problems such as tuberculosis, malaria, leprosy, diabetes, hypertension, heart care, eye care and the like are marketed only as generic preparations.
- Ensure that unbiased and comprehensive information, including the information relating to the comparative costs of medicines and the total treatment regimen, be in the public domain and be made available to prescribers as well as patients.
- Set up an independent competent body to ensure that all new drugs introduced in the market from within India or abroad should be allowed in the country only if it meets the criteria of lower costs, better efficacy and less side-effects, and after it undergoes testing in accordance with Schedule Y in the Drugs and Cosmetics Act.
- Ensure access to newer, more efficacious and more affordable drugs post 2004, if necessary by using options such as compulsory licensing and parallel imports available under the WTO/TRIPS agreements.
- Increase the healthcare budgetary allocations so as to realise the fundamental right to health care for all the people of India.

Sale and Stocking of Drugs

In **Holy Cross Hospital vs. State of Kerala**[16] the Petitioner was a charitable hospital that stocked medicines for its patients. The petition challenged the order of Drug Controller enforcing the system of Drugs Licence to Petitioner's hospital. Section 18 of the Act states that sellers, stockiest and persons similarly situated are obliged to secure license before stocking drugs. Charitable hospitals were earlier exempted from this requirement but through an amendment this exemption was withdrawn and this was challenged.

The Government of India via its G.S.R. 812(6) dated 14.11.1994 continued the exemption only in favour of registered medical practitioners, and hospitals/dispensaries maintained or supported by Government or local authorities.

The high court, however, held that the broad classification between private or charitable hospitals and hospitals/dispensaries under the supervision of Government or local medical bodies was valid and there was nothing unconstitutional in requiring private hospitals to get license for stocking drugs.

In the case of **Kasim Bhai vs. State of UP,**[17] the accused was the owner of a medical shop that was duly licensed. However he was charged with:

i) Possession of drugs covered by Schedule H without having a qualified man under whose supervision sale of such drugs could be executed; and
ii) he was found in possession of and exhibiting for sale expired penicillin ointment.

Rule110 Sub-rule 9 of Rule 65 of Drugs and Cosmetics Rules reads "Substance specified in Schedule H, and preparations containing such substances, shall not be sold by retail except on and in accordance with a prescription of a registered medical practitioner provided that no prescription shall be required for sale or supply to a registered medical practitioner, hospital, infirmary, or an institution approved by an order of a licensing authority."

The high court held that Sub-rule 9 referred to sale of drugs specified in Schedule H whereas charges against the accused were for storage of such drugs and not for sale of these drugs. Hence he was absolved of his first charge. As regards the second

[16] Kerala HC decided on 25/2/2002
[17] AIR 1956 Allahabad 703

charge, it was contended by the accused that there was nothing on record to show that the penicillin tubes were kept in the shop or were exhibited there for purpose of sale. The high court, however, did not accept this defence and held that when a particular medicine is kept in the shop there would be a presumption that it was for the purpose of sale unless that presumption is rebutted by the accused.

In **Bharat Prasad Gupta vs. State of West Bengal**[18] allopathic medicines and instruments were seized from the dispensary of the Appellant where they had been exhibited for sale. He was held guilty under Section 27 of the Drugs Act and sentenced to imprisonment of a year by the high court. The Supreme Court upheld his guilt, but reduced the sentence to that already undergone by the Appellant, which was about 2 months.

Swantraj vs. State of Maharashtra[19] was an important case concerning the storage of drugs in transit. The Appellant had a wholesale dealer license to stock drugs at Bombay and a further license to distribute the drugs through the motor van throughout the territory of Maharashtra. The Appellant booked certain drugs to distribute in the licensed area. The van which was to receive the stock was held up for a few days. The delivery was received by one of the partners of the Appellant-firm who temporarily stored the drugs in the godown of a local drug dealer prior to loading the van when it arrived. The charge against the Appellant-firm was that it did not have the licence to stock the drugs at the latter place, and therefore they acted in contravention of the provision of Drugs and Cosmetics Act, and were liable for punishment under S.27(b).

The issues before the Supreme Court were:

1. Whether temporary deposit of drugs in a place outside Bombay for which place Petitioners had no license to stock goods, amounts to stocking for sale or distribution (for which license is required)?
2. Whether stocking with the purpose of selling the drugs at another and not the place of stocking requires a licence? In other words, whether it can be inferred that drugs stocked are stocked for sale?

The Supreme Court interpreted Rules 61 and 62 to draw the conclusion that the Rules specify the forms that may be issued and the content and purpose thereof. There is no scope of reading anything into it. The Rules do not cover storage in transit. Storage in transit must also be licensed so that medicines do not suffer in the process.

The Appellant pleaded that license should not be insisted upon for every place of make-shift storage in far-flung areas. The Supreme Court stated that the paramount purpose of regulation through licensing was to set in motion vigilant medical watch over maintenance of the standard quality of drugs and medicines and verification of its expiry date and spuriousness of the products. If godowns, temporary stores and depots remained unlicensed, they escaped official attention and could deteriorate into pools of dubious or deceptive drugs harmful to society. Every place where storage for sale is made must be licensed.

The second issue was whether goods stored in transit would be considered to be stocked for sale. The Supreme Court held in the affirmative after relying on the 'Doctrine of mischief' which states that such interpretation of a statute must be upheld that serves its purpose even if by doing so some persons' interest is wrongly affected so that mischief by those who would use any other judicial interpretation to serve their purpose in contravention to the general object of the statute is avoided.

The Supreme Court thus concluded:

1) Licences under Rules 61 & 62 proviso will extend to grant of licences for wayside depots or 'emergency stores' or 'vehicles', but every storage for sale must have a licence.

[18] (1995) SUPP 3 SCC 640
[19] (1975) 3 SCC 322

2) Licences permitting sale by a vehicle cannot automatically cover cases of 'emergency storage' or storage in transit. The words of Section 18(c) and Rule 62 are mandatory being plain and admitting no exceptions.
3) Applying the mischief rule of interpretation, storage even though for a short spell or on an ad hoc basis and without intent to sell at that place but as a part of the sale business comes within the scope of 'storage for sale' in Section 18(c) & Rule 62.

In **Sagar Medical Hall vs. State of Bihar,**[20] a petition was filed against the order of State Government restraining the regional licensing authorities from issuing or renewing licence for the wholesale and retail sale of drugs. The State Government's justification for its policy decision was that the ban on the issuance of wholesale and retail drug licences was a temporary measure to prevent the spurt of spurious drugs. There were adequate drug stores to meet public need. A mushrooming of drug stores would lead to a decline in turnover and loss, which would cause drug stores to sell spurious drugs to sustain themselves.

The Petitioners contended that license cannot be refused when all the conditions attached to it have been complied with. The Act does not impose any such ban or give power to impose such a ban.

Rule 64 provides for conditions subject to which a licence shall be granted or renewed.

The high court held that the grant and renewal of drug licence is governed by statutory rules and nowhere do such rules provide that the license can be declined or renewal refused on the ground that the State Government reckons that the number of shops are sufficient to meet demand of public. Thus, executive decisions of the State cannot override the statutory provisions. The growth of drug stores is to cater the needs of public. The State cannot regulate the grant of license because they cannot efficiently control them . The State Government has an entire department to control and prevent sale of spurious drugs.

Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954

The object of this Act is to prevent self-medication and the inducement to take drugs for certain specific disease, condition or disorder, by advertising its alleged magical properties or healing power.

In **Hamdard Dawakhana vs. Union of India**[21] the constitutionality of the Act was challenged before the Supreme Court on the ground that it violates the freedom to speech and expression under Article 19(1)(a).[22]

The Supreme Court upheld the Constitutionality of the Act and to begin with held that though it was true that advertisements were protected under Article 19(1)(a) concerning freedom of expression, commercial advertisements were not so protected. The Court further held:

The advertisements prohibited by S.3 of the Act relate to commerce or trade and not to propagation of ideas, and advertising of prohibited drugs and commodities of which the sale in not in public interest, cannot be speech within the meaning of freedom of speech and would not fall within Art/. 19(1)(a). As the main purpose and true intent and aim, object and scope of the Act is to prevent self medication or self-treatment and for that purpose advertisements commending certain drugs and medicines have been prohibited, it cannot be said that this is an abridgement of the Petitioner's right to free speech

In **State of Karnataka vs. R.M.K. Sivasubramanya Om**[23] the drug inspector raided the hotel room where the Respondent was staying pursuant to an advertisement published in

[20] (CWJC) Patna HC dt. 7/12/01
[21] AIR 1960 SC 554
[22] Sections 3(d) & 8 were also challenged for giving unhindered power to the executive under the Act, and both were held ultra vires. In 1963, Parliament rectified the flaws.
[23] 1978 CRI.L.J. 853 (Karnataka HC)

a local paper, and seized drugs used to treat tuberculosis and sexual rigour and literature relating to these drugs. The advertisement read as:

All diseases of any nature and how-long-standing they may be are well attended to with utmost care. To restore, regain and to retain vim, vigour and vitality, use our 73 years very popular fully vitaminised special invigorative nervine tonic for all. Amazatone with Ton Oil Cost per set Rs.147/- Medicines are available for all diseases. Consult the Siddha Hakeem

The high court opined that for a person to be liable under S.3 three ingredients are required, namely,

i) Accused should have taken part in the publication of an advertisement
ii) The advertisement should relate to or should have reference to a drug.
iii) Such a drug should be suggested as a cure for diseases, conditions or disorders specified under S.3.

Since the contravention of S.3 is made punishable, it should be construed strictly. The high court did not hold the Respondent guilty for the followings reasons:

i) It was not proved that Accused himself had authorized the publication of the advertisement.[24] The Advertisement Manager of the local paper in his deposition stated that though the advertisement in question was published on behalf of the Accused but it was not made clear who authorized the Manager to publish on behalf of the Accused.[25]
ii) There was no evidence to show that he had taken the seized drugs outside his hotel room for the public to see. There was no evidence to show that the accused had sent the literature or bottles outside for distribution. The material available on record merely pointed to the fact that the Drug Inspector had seized the articles from the possession of the accused when he was in his hotel room.
iii) It was mentioned that 'Amazatone' is a special invigorative nervine tonic useful for all and will help to restore, regain and retain vim, vigour and vitality. It was nowhere even obliquely stated that it is a cure for impotence or that it helps the maintenance or improvement of the capacity of human beings for sexual pleasure. There was also no reference to Tuberculosis.

Dr. Yash Pal Sahi vs. Delhi Administration[26] was a case where the Appellant was the proprietor of a homeopathic hospital and the publisher of a journal named *Homoeopathic Doctor*. In a sting operation carried out by the Respondent, Appellant was asked to send copies of the journal and a list of medicines printed by it. This was sent. The list of medicine had a note stating "for the use of medical practitioners alone".

The Appellant's case was that he was protected under S.14 (1) (c). Rule 6 of the Rules framed under the Act prescribe that:

All documents containing advertisements relating to drugs, referred to in clause (c) of Sub-section (1) of Section 14, shall be sent by post to a registered medical practitioner or to a wholesale or retail chemist...Such documents shall bear on top, printed in indelible in a conspicuous manner, the words 'For use only of registered medical practitioners or a hospital or a laboratory.

He claimed that as the list bore the words printed in indelible ink 'For the use of registered medical practitioners' he had complied with the provisions of law.

The Supreme Court held that the person to whom the list of medicine was sent was not a medical practitioner and the Appellant did not even verify his profession before sending such a list. Therefore, Appellant's case did not fall under S14 (1) (c) and he was guilty under S.3.

---

[24] S.6 prohibits import or export of any document containing advertisements of such nature as specified in Ss. 3, 4 & 5, S. 25 & S.9

[25] ibid para 13. The Advertisement Manager earlier in his statement before police had admitted that the advertisement was published at the behest of the Accused. The Manager retracted his statement by deposing that he had signed certain the statement without reading it. The Court expressed that the advertisement was not sufficient to hold the Accused guilty.

[26] (1963) 5 SCR 582

The Punjab and Haryana High Court was required to consider similar advertisements in the case of **K.S.Saini vs. Union of India**[27]. The advertisement read:

"We have treated thousands of men and women for the last 15 years with the help of science which has resulted in their getting children and making their home a heaven. We undertake every treatment with the latest methods of science and we have got proof that those sisters who did not get any issue for 20/25 years have got children with our treatment. The addresses of those persons are given below. In our hospital the following diseases are treated with the latest methods of science and the aid of electricity." Thereafter certain diseases were mentioned and some of those did fall under the Schedule mentioned in Section 3 (d) of the Act as amended.

The Court observed:

The question, however, is: Does this passage refer to any drug and is its language such as suggests or is calculated to lead to the use of any drug for any of the diseases mentioned in the Schedule? No drug is mentioned in this part of the pamphlet and all it says is that "we undertake the treatment of various diseases by latest methods of science and with the aid of electricity." It cannot, therefore, be suggested that this part of the pamphlet refers to any drug or suggests to anyone the use of any drug. The object of the Act is to avoid self medication by people or their being misled by various advertisements. The necessary condition, therefore, is that the advertisement must induce others into using the drug advertised. If someone says that "I undertake the treatment of an ailing person by scientific methods with the aid of electricity" it cannot amount to a suggestion for the use of any drug.

In **Zaffar Mohammad vs. State of West Bengal,**[28] the advertisement in question that was published in a local paper was as follows:

New life, New vigour, New spirit, New wave.

If you want a cure, see today well known, world famous experienced registered Physician. Special diseases such as oldness in youth, all sorts of defects in nerves, or weakness, laziness are treated with full responsibility, with new methods, new machines of science and electric treatment and are cured permanently.....

'Disorders of the nervous system' is Item No.14 of the Schedule to the Act, hence the issue was whether the treatment and machines referred to in the advertisement were drugs for S.3 to apply.

The Supreme Court held that

Any article, other than food, which is intended to affect or influence in any way any organic function of the body of a human being is a 'drug' within the meaning of S.2(b)(iii). The so-called 'machines of science' or of 'electric treatment' whose magically curative properties were advertised in a newspaper by the Appellant to cure nervous diseases, and designed according to advertisement to confer on mankind the blessings of new life and new vigour, are 'articles' intended to influence the organic function of the human body. A machine is a tangible thing which can both be seen and felt and as such it answers the description of an 'article' within the meaning of S.2(b)(iii) of the Act.

Such an advertisement was therefore not permitted and the accused had committed an offence.

In **Kantirani Jaynarayan Mangal vs. State of Maharashtra,**[29] the Bombay High Court was concerned with an order of conviction passed against the Petitioner under the Magic Remedies Act. The accused was selling an article known as 'Bust Developer' which was an instrument sold along with a booklet meant for enlarging the bust. The advertisement mentioned,

With proper, careful and patient use over the period it should leave very underdeveloped and insufficiently developed girl or woman satisfied with the result.

---

[27] AIR 1967 P&H 322
[28] AIR 1976 SC 171
[29] 1982 MLJ 822

The accused argued that the bust developer was meant for beautification and it could not be classified as a drug. The Court held that Magic Remedies Act would only be applicable to those articles that deal with certain ailments. The court also felt that the object of the Act was to prohibit such magic remedies which are shown to be immediate and forthwith cure giving hopes to customers in a magic fashion. "Remdies provided for health, sociality or developing beauty is not hit by Section 3." Since the advertisement did not have reference to any ailment it would not be a prohibited advertisement. The accused was acquitted.

I feel that this judgment is erroneous especially in view of the Supreme Court's judgment noted above.

In **Anand Mohan Chapparwal vs. State of Maharashtra**[30] the Bombay High Court was concerned with an advertisement which read:

For Men Only 303 Capsules (Three not three) contains highly potent and time tested HERBS & MINERALS in combination with the celebrated ingredients MOTIBHASMA, KESHAR, KASTURI traditionally known for their efficacious therapeutic properties for enhancing vigour and vitality. Now this ancient AYURVEDIC formula can be used by you too as once used by RAJAS, MAHARAJAS AND NAWAB for ADULT MALES only. Available at all leading Chemists.

SHATAKARAM PHARMACEUTICALS P.O. BOX. NO. 25 GWALIOR 474001 STOCKIST : SURAJ PHARMA Station Road Hubli.

The Petitioner submitted that the advertisement in question did not attract the mischief of Section 3(b) read with Section 7(a) of the Act as it did not suggest or calculate to lead to the use of that drug for any of the clause enumerated in Section 3(a) to (d) of the Act. For convenience Section 3 of the Act is extracted below:

3. Prohibition of advertisement of certain drugs for treatment of certain diseases and disorders. - Subject to the provisions of this Act, no person shall take any part in the publication of any advertisement referring to any drug in terms which suggest or are calculated to lead to the use of that drug for - (a) the procurement of miscarriage in women or prevention of conception in women; or (b) the maintenance or improvement of the capacity of human beings for sexual pleasure; or (c) the correction of menstrual disorder in women; or (d) the diagnosis, cure, mitigation, treatment or prevention of any disease, disorder or condition specified in the Schedule, or any other disease, disorder or condition (by whatsoever name called) which may be specified in the rules made under this Act.

In this case the court was concerned only with sub-clause (b) of Section 3 of the Act. The court held:

If we glance through the section it can be seen that in order to attract the said section, the advertisement should suggest or calculate to lead to the use of a particular drug for the maintenance or improvement of the capacity of human beings for sexual pleasure. On a plain reading of this sub-section (3)(b) of the Act it is easily discernible that unless the advertisement creates an impression the readers of the advertisement and influence their mind that the drug is intended to suggest or calculated to lead to the use of the same for sexual pleasure, the section will not be attracted. As we have seen in the advertisement, it is nowhere mentioned about sex. It is of course mentioned that the drug is confined only to the menfolk to improve their vigour and vitality. It is common knowledge that an advertisement either visual or audio may create different reaction in different men and women. In normal case if an advertisement is susceptible or possible to convey to the general public more than one idea, the criminal jurisprudence will take cognizance only of those impressions which are capable of interpretation in favour of the accused. If the advertisement is capable to convey an idea different from what the complainant had and the same is in favour of the accused undoubtedly the advertisement should be interpreted in favour of the accused. Therefore

[30] 1996 CR LJ 596

upon the psychology and mental fabric of an individual reader, it may not perhaps be ruled out the possibility of having the impression about advertisement like one had in the mind of the respondent. But that alone will not lay a foundation to sustain a criminal complaint before a Criminal Court against an accused.

Patents Act

The major cases on the Patents Act have been around the issue of parameters of a patent. This will change now with the amendments to the Patents Act coupled with India's obligation under TRIPS, and the increasing efforts by pharmaceutical companies to profit from the changes in the law. This has become possible especially because patents are now available not just for processes but also for products. The new Patents Act is characterised by two main trends. On the one hand, it generally follows quite closely the requirements of the TRIPS Agreement. The amendments thus generally alter the balance between the interests of patent holders and the interests of society at large in favour of the former. The duration of patents in the health sector has been, for instance, dramatically increased from seven to 20 years. The amendments also strike out an important provision of the Act seeking to oblige patent holders to manufacture their inventions in India. On the other hand, the new Patents Act uses some of the exceptions and qualifications included in TRIPS to foster public health goals. It uses, for instance, health-related exceptions in Sec.3 of the Act which determines which inventions are not patentable. Some of the most interesting and most controversial new provisions are found in the chapter on compulsory licensing. While TRIPS generally imposes a stricter compulsory licensing regime than that provided under the Patents Act, 1970, the amendments make use of some of the possibilities opened by the Doha Declaration. The section of the compulsory licensing chapter (Sec. 83) that sets out the general principles applicable to compulsory licensing is particularly noteworthy. It specifically mentions that patents granted should not 'impede protection of public health' and should not prohibit the Central Government from taking measures to protect public health. Further, it recalls that patents should be granted to make the benefits of the patented invention available at reasonably affordable prices to the public.

The future can be well assessed from a recent case before the Controller of Patents[31]. Novartis filed for a patent concerning a drug for the treatment of cancer. This was opposed by the Cancer Patient's Aid Association (CPAA) on the ground that the patent applied for was only an extension of the earlier patent of the same drug beyond the prescribed period for which a patent can be validly held. Essentially, the argument of the opponents was that the company was indulging in 'evergreening' i.e. trying to continue the patent beyond the prescribed date by claiming that the drug was a newly invented one, whereas, in fact, the changes were minor obvious non inventive ones. The Controller upheld the arguments of the Opponents and refused to proceed with the patent effectively coming to the conclusion that Novartis were resorting to evergreening. The patent application was rejected on three grounds – anticipation by prior publication, obviousness, priority, and also on the ground that the product was a derivative of a known substance. As per Section 3(d) of the Patents Act, no salt, polymorph or derivative of a known substance is patentable unless it shows enhanced efficacy of the substance.

However in May 2006, Novartis filed two cases against the Government of India and CPAA challenging the rejection of its patent application and questioning the validity of section 3(d) of the Indian Patents Act.

Imatinib Myselate (Gleevec) is a life saving drug essential in prolonging the life of patients suffering from Myeloid Leukemia (Blood Cancer). The order of the Chennai patent office brought relief to thousands of cancer patients as it prevented a patent monopoly on 'Gleevec' till 2018.

---

[31] In the matter of an application for patent No. 1602/MAS/98 filed on July 17, 1998. Order of the Controller of Patents dated 25th January, 2006.

Adv. Mihir Desai, Adv. Dipti Chand

The case is significant because this important cancer drug produced and marketed by Novartis was sold at a whopping Rs. 1,20,000 ($ 2500) per patient per month while generic versions of 'Gleevec' in India were priced at a fraction of that amount, i.e. about Rs. 8,000 ($ 175) per patient per month. Cancer groups provide the more affordable generic versions of 'Gleevec' to Indian cancer patients. This case is also important since the Indian law is being challenged by a private entity, and in this case a foreign company.

Conclusion

According to the WHO, essential medicines are those that satisfy the priority health care needs of the population. These medicines are selected keeping in mind their public health relevance, evidence of safety and efficacy, and cost-effectiveness. Essential medicines are intended to be available in the context of a functioning health system at all times in adequate quantities, in appropriate dosage forms with assured quality and reliable information, and at a cost that the community and individuals can afford.

Health care laws relating to drugs deal with three aspects: (i) Accessibility to drugs; (ii) dispensation of drugs and (ii) quality of drugs. There are sufficient provisions in the law to control quality through licensing, supervision and provision of standards. Misleading advertisements are also prohibited. Most of the litigation concerning drugs has been on these aspects, though overwhelmingly initiated by manufacturers and traders rather than by consumers. Dispensation is also covered widely under the law. The Drugs Act and Rules provide for those drugs that can be sold over the counter and those that can only be sold under a medical prescription. The Pharmacy Act as well as the Drug Act and Rules lay down the conditions under which Drugs can be prepared, dispensed and sold.

However, legal provisions concerning affordability and accessibility to drugs are few and even these have been whittled down over a period. Also, there has not been much litigation on these issues, though there are a few concerning drug price controls and similar issues pending before the courts.

Eight

Right of Workers to Occupational Health and Safety

Adv. Mihir Desai and Adv. Dipti Chand

Introduction

This Chapter addresses issues that impinge on the health and safety of the worker under Indian laws:

- Who is eligible to claim compensation under the occupational health laws? Specifically, can workers of the unorganized sectors claim compensation?
- What are the provisions available in the laws for workers health care rights?
- To what extent are employers liable for the health problems of employees?

Working conditions and the nature of employment tend to have major repercussions on the health of workers. The concept of 'Occupational Health' has evolved from work-related ailments. Occupational health broadly means any injury, impairment or disease affecting a worker or employee during his course of employment. Further, it not only deals with work-related disorders but also encompasses all factors that affect community health.

Occupational injuries and diseases

Data on the overall incidence/prevalence of occupational disease and injuries for the country is poor. Leigh et al. (1999) have estimated an annual incidence of occupational disease between 924,700 and 1,902,300 and 121,000 deaths in India. A survey of the incidence of injury in agriculture in Northern India [Mohan and Patel, 1992] shows an annual incidence of 17 million injuries per year, (2 million moderate to serious) and 53,000 deaths per year in agriculture alone.

The major occupational diseases/morbidity of concern in India is silicosis, musculoskeletal injuries, coal workers' pneumoconiosis, chronic obstructive lung diseases, asbestosis, byssinosis, pesticide poisoning and noise-induced hearing loss. Census figures (2001) have revealed that there is an increase of about 28 per cent male workers and 45 per cent female workers from 1991 to 2001. During the past decades, the population of working females has rapidly increased. The proportion of male: female working population, which was 78:22 in 1991, changed to 68:32 in 2001. This increase in the working female population leads to certain concerns, such as adverse effects on reproduction, exposure to toxic chemicals in the workplace, musculoskeletal disorders because neither the tasks nor the equipment they use, are adapted to their built and physiology. In addition, female workers have specific stress-related disorders, resulting from job discrimination (such as lower salaries and less decision-making), a double burden of work (workplace and home) and sexual harassment.

With 75 per cent of the global workforce living in the third world countries, more than 125 million workers are victims of occupational accidents and diseases every year[Kanhere, 2005] With the changing job patterns, working relationships, the rise in self-employment, outsourcing of work, etc. the management of occupational safety and health risks has been problematic. Nevertheless particular attention needs to be paid to the health and safety of workers in 'hazardous occupations' and especially migrant workers and other vulnerable persons. Work related hazards and occupational diseases in small-scale industries and agriculture

are likely to increase as the occupational safety and health services are out of reach in these occupations. However, with increasing Public Interest Litigations (PILs), proactive legislations and continual struggle by environmental activists, the awareness with respect to occupational health concerns are gaining more ground.

The Indian Constitution has shown notable concern about workers in factories and industries as evidenced in its Preamble and the Directive Principles of State Policy. The Directive Principles of State Policy provide:

a) For securing the health and strength of workers, men and women;
b) that the tender age of children is not abused;
c) that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength;
d) just and humane conditions of work and maternity relief are provided; and,
e) that the Government shall take steps, by suitable legislation or in any other way, to secure the participation of workers in the management of undertakings, establishments or other organizations engaged in any industry.

Occupational Health Laws

The Factories Act, 1948, The Mines Act, 1952, The Dock Workers (Safety, Health & Welfare) Act, 1986 are some of the laws, that regulate the health of workers in an establishment. The Employees State Insurance Act, 1948 and the Workmen's Compensation Act, 1923 are compensatory in nature.

The Factories Act, 1948 prescribes safety conditions for manufacturing processes. It also offsets down provisions specific to factories involved in producing hazardous substances, for eg. Sections 41 a – h and other. The Workmen's Compensation Act deals with compensation to workers who suffer injuries at the place of work and suffer from specified occupational diseases. The Employees' State Insurance Act, 1948, deals with compensation and also access to free medical care for employees including the setting up of dispensaries, hospitals and panel doctors for employees. The Maternity Benefit Act is concerned with paid medical leave and other benefits to women workers when they are pregnant. Apart from these general laws, certain specific Acts such as the Beedi and Cigar Workers Act, Mines Act, also deal in a limited way with health care for workers.

The first Factories Act was passed in 1881 in British India. The act was amended in 1891, 1911, 1923, 1934 and 1948 to bring the legislation in line with the British Factory Act. The Bhopal Gas tragedy (1984) was a turning point in legislation pertaining to occupational health and safety in India. The Factories Act was amended (1987) and it stipulated the qualifications/strength of occupational health staff in hazardous industries. Currently 29 diseases have been included as 'notifiable' occupational diseases under this Act.

Before the 1920s, it was believed that an employee by entering into a contract with the employer accepts the risks involved in employment and cannot hold the employer liable for injury or disease related to employment. But after the 1920s, when the Employers Liability Act was enacted, it has been recognized that because of the unequal relationship between employer and employee no such presumption can be made. All these laws also recognize that it is the responsibility of the employer to provide a safe work environment for employees. Over the years, the laws have been amended to bring in more detailed safety provisions for employees.

Most of these enactments are over 50 years old and obviously have attracted a large number of litigations. The Workmen's Compensation Act and the ESI Act especially have been much used by employees. An overwhelming amount of litigation has been on classifying a particular injury or disease is employment-related or not. Questions such as whether a heart attack suffered by an employee at the work place constitutes employment-related injury or whether an accident to the employee during his commute to work may be so classified. Other cases have been around issues concerning the extent of injury and occupational disease. But we will not cover those in the scope of this book.

Here we will look at some aspects mainly flowing from the Supreme Court's assertion that workers have a fundamental right to work in a healthy environment. Here we will deal with some aspects not dealt with in the earlier chapter.

Article 39(e) charges that the policy of the State shall be to secure 'health and strength of the workers'.

Article 42 mandates that the States shall make provision, statutory or executive 'to secure just and humane conditions of work.'

Article 43 directs that the State shall endeavour to secure to all workers, by suitable legislation or economic organization or any other way, a decent standard of life and full enjoyment of leisure and social and cultural opportunities.

Article 25(2) of the Universal Declaration of Human Rights promises the right to a standard of adequate living for health and well-being of the individual including medical care, sickness and disability.

Article 2(b) of the International Covenant on Political, Social and Cultural Rights protects the right of worker to enjoy just and favourable conditions of work ensuring safe and healthy working conditions.

As regards health care, Section 10 of the Factories Act lays down that a State Government may appoint qualified medical practitioners as 'certifying surgeons' to discharge the following duties:

a) Examination and certification of young persons and examination of persons engaged in 'hazardous occupation'.
b) Exercising medical supervision where the substances used or new manufacturing processes adopted may result in a likelihood of injury to the workers.
c) Exercising medical supervision in case of young persons to be employed in work likely to cause injury.

Chapter IX of the Act lays down in detail the provisions relating to the health, safety and welfare measures, namely, cleanliness, level of ventilation, diversion of dust and fumes, provision of artificial humidification, sanitation, fencing of machinery, among others. There are also provisions that prohibit women n\and children from working in certain occupations. 27 processes and operations have been identified as dangerous in The *Maharashtra Factories Rules, 1963*. These Rules lay down detailed instructions regarding preventive measures, protective devices, cautionary notices as well as medical examination of workers. The State Governments have adopted these rules depending on their local needs. The Act lists 29 occupational diseases and obliges the factory managers and medical practitioners to notify the Chief Inspector of Factories if a worker contracts any of the diseases.

S. 45 of the Factories Act also mandates that every factory for every 150 workers there should be at least one first aid box to be in charge of a person who holds a certificate in first aid from the State Government. Besides, every factory with more than 500 workers is required to have an ambulance room and prescribed medical and nursing staff. Each State Government has its own rules under the Factories Act. For instance, **Rule 76** of the Maharashtra Factories Rules prescribes a detailed list of the items that are mandatory in a First Aid Box. There is a further sub division depending on whether the factory uses mechanical power or not. **Rule 78** prescribes that in every factory which employs more than 500 workers the Ambulance Room must be in the charge of a qualified medical practitioner with at least one qualified nurse.

Similarly, in what are classified as hazardous processes, **Section 41C** of the Factories Act provides that employees must be medically examined before they are employed in such processes and should be so examined once every year during the time they are in employment and even after the cessation of employment for such a period as may be prescribed. **Rule 73** of the Maharashtra Factory Rules also prescribes that every factory involved in hazardous process must have at least one fully equipped ambulance van.

Similarly, the ESI Act, provides for medical care to registered employees in cases not just of

accidents and occupational diseases but also of ordinary illnesses. The scheme extends to the families of the employees. The Act does not cover 'seasonal employments'. It defines 'employment injury' as personal injury to employees, caused by accident or occupational diseases, in an insurable employment. The Act lays down provisions to set up an ESI Corporation, to promote measures to improve health and welfare of insured persons and a Medical Benefit Council to advise the Corporation on medical benefits, certification, etc. The Medical Boards have to ascertain the percentage of disability of injured workers before submitting their report to the Corporation in order to grant compensation to the workers. An injured worker has to wait for months before the Medical Board calls him for a check-up [Kanhere 1995].

Case Law

In **Consumer Education and Research Centre vs. Union of India**[1] the Supreme Court was concerned with rights of employees in the asbestos manufacturing industry. It was a public interest litigation filed concerning conditions of work and health affects on workers.

In this crucial decision the Supreme Court held that the right to health of a worker is an integral facet of a meaningful right to life to have not only a meaningful existence but also robust health and vigour without which the worker would lead a life of misery. The lack of health denudes his livelihood. Compelling economic necessity to work in an industry exposed to health hazards should not be at the cost of the health and vigour of the worker. Facilities and opportunities, as enjoined in Article 38, should be provided to protect the health of the worker. The provision for medical test and treatment invigorates the health of the worker for higher production or efficient service. The Court further held that continued treatment, while in service or after retirement is a moral, legal and constitutional concomitant duty of the employer and the State. Therefore, it must be held that the right to health and medical care is a fundamental right under 21 read with Article 39(c), 41 and 43 of the constitution to make life of the workman meaningful and purposeful with dignity of person. Right to life includes protection of the health and strength of the worker and is a minimum requirement to enable a person to live with human dignity. The State (Central and State) government or an industry, public or private, is enjoined to take all such action which will promote health, strength and vigour of the workman during the period of employment and leisure and health even after retirement as basic essentials to live the life of health and happiness.

The Supreme Court went on to observe that the right to human dignity, development of responsibility, social protection, right to rest and leisure are fundamental human rights to a worker assured by the Charter of Human Rights, in the Preamble and Arts. 38 and 39 of the Constitution. The health of the worker enables him to enjoy the fruit of his labour, keeping him physically fit and mentally alert for leading a successful life, economically, socially and culturally. Medical facilities to protect health of the workers are, therefore, the fundamental and human rights of the workmen.

The court also held that in an appropriate case, the court would give directions to the employer, be it the duty of the State or its undertaking or a private employer to make the right to life meaningful; to prevent pollution of the work place; protect the environment; protect the health of the worker or to ensure free and unpolluted water for the safety and health of the people. This was an important observation because ordinarily, under its Constitutional jurisdiction the Supreme Court gives directions only to State authorities and not to private individuals or employers.

The employer is vicariously liable to pay damages in the case of occupational diseases, here in this case asbestosis. The Employees State Insurance Act and Workmen's Compensation Act provide for payment of mandatory compensation for the injury or death caused to the worker while in employment. Since the Act does not provide for payment of compensation after the cessation of

[1] AIR 1995 SC 992

employment, it becomes necessary to protect such persons from the respective dates on cessation of their employment.

The Court observed:

The Employees State Insurance Act and Workmen's Compensation Act provide for payment of mandatory compensation for the injury or death caused to the workman while in employment. Since the Act does not provide for payment of compensation after cessation of employment, it becomes necessary to protect such persons from the respective dates of cessation of their employment till date. Liquidated damages by way of compensation are accepted principles of compensation.

The Court, while allowing the Petition, ordered in respect of Asbestos industries:
All the industries are directed

a) to maintain and keep maintaining the health record of every worker upto a minimum period of 40 years from the beginning of the employment or 15 years after retirement or cessation of the employment whichever is later;
b) the Membrane Filter test to detect asbestos fibre should be adopted by all the factories or establishments on a par with the Metalliferrous Mines Regulations, 1961 and Vienna Convention and rules issued there under;
c) all the whether covered by Employees State Insurance Act or Workmens Compensation Act or otherwise are directed to compulsorily insure health coverage to every worker;
d) the Union and all the State Governments are directed to consider inclusion of such of those small scale factory or factories or industries to protect health hazards of the workers engaged in the manufacture of asbestos or its ancilliary products; and
e) The appropriate inspector of factories in particular of the State of Gujarat, is directed to send all the workers, examined by ESI hospital concerned, for re examination by the National Institutie of Occupational Health to detect whether all or any of them are suffering from asbestosis. In case of positive finding that all or any of them are suffering from occupational health hazards, each such worker shall be entitled to compensation in a sum of rupees one lakh payable by the factory or industry or establishment concerned within a period of three months from the date of certification by the National Institute of Occupational Health.

In **Rajangam, Secretary, Dist. Beedi Worker's Union vs. State of Tamil Nadu** [2] the issue concerned conditions of work of employees in beedi manufacturing and allied industries. A large number of children are employed in this work.

The Supreme Court passed the following directions:

1. Tobacco manufacturing is indeed health hazardous. Child labour in this trade should therefore be prohibited as far as possible and employment of child labour should be stopped either immediately or in a phased manner to be decided by the State Governments but within a period not exceeding three years from now. The provisions of Child Labour (Prohibition & Regulation) Act, 1986 should be strictly implemented.
2. The Beedi Workers Welfare Cess Act, 1976 and the Beedi Workers Welfare Fund Act, 1976 which contain beneficial provisions should be implemented in the true spirit and since they are legislations of the Central Government, the machinery of the Central Government should be made operational in the area.
3. In view of the health hazard involved in the manufacturing process, every worker including children, if employed, should be insured for a minimum amount of Rs 50,000 and the premium should be paid by the employer and the incidence should not be passed on to the workman.

In **Bandhua Mukti Morcha vs. Union of India,**[3] a PIL was filed against the employment of children below 14 years of age in the carpet industry in Uttar Pradesh and in most cases; the children were forced to work. The petitioner sought

[2] AIR 1993 SC 401
[3] AIR 1997 SC 2218

directions for the total prohibition on employment of children below 14 years of age and directions to the Respondents to give them facilities like education, health, sanitation, nutritious food, etc. It was also contended that the employment of children in any industry or in a hazardous industry violated Art. 24 of the Constitution. [4]

The Court held that the imperatives of Directive principles of State policy, read with the Preamble, Article 21, 23 [5]and 24 of the Constitution enjoins upon the State to ensure socio-economic justice to the child and their empowerment, full growth of their personality— socially, educationally and culturally— with a right to leisure and opportunity for development of the spirit of reform, inquiry, humanism and scientific temper to improve excellence- individually and collectively. In specific, the State has the responsibility to formulate policy to protect children of tender age from abuse (Art.39e); to provide opportunities and facilities for their development in a healthy manner and in conditions of freedom and dignity and protect their childhood and youth against exploitation and moral and material abandonment (Art.39f); free and compulsory primary education for all children (Art. 45); and prohibit employment of the children below the age of 14 in any factory or mine or any hazardous employment (Art.24).

Child labour is a social phenomenon with its genesis in poverty and cannot be completely eradicated except by social changes even though it violates the right of the child to a meaningful life, leisure, food, shelter, medical aid and education. Total banishment of employment may drive the children and mass them up into destitution and other mischievous environment, making them vagrant, hard criminals and prone to social risks etc. Thus progressive elimination of employment of children below the age of 14 years would be required.

Article 27(1) provides that the state parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

Article 31(1) recognizes the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.

Article 32 which is material for the purpose of this case reads as under:

1. State parties recognise the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.
2. State parties shall take legislative, administrative, social and educational measures to ensure the implementation of the present article. To this end, and having regard to the relevant provisions of other international instruments, State parties shall in particular:
   - Provide for a minimum age or minimum ages for admission to employment;
   - Provide for appropriate regulation of the hours and conditions of employment;
   - Provide for appropriate penalties or other sanctions to ensure the effective enforcement of the present article.

Thus, Supreme Court directed the Central Government to convene a meeting of the concerned State Ministers and Principal Secretaries holding relevant departments within two months of the receipt of this Order, to evolve principles of policies for progressive elimination of employment of children below the age of 14 years in all employments governed by the respective enactments mentioned in MC Mehta Case[6]; and

---

[4] No child below the age of fourteen years shall be employed to work in any factory or mine or engaged in any other hazardous employment.

[5] Traffic in human beings and begar and other similar forms of forced labour are prohibited and any contravention of this provision shall be an offence punishable in accordance with law

[6] M.C.Mehta vs. State of T.N.: [(1991) 1 SCC 283] The Supreme Court directed that children should not be employed in hazardous jobs in factories for manufacture of match boxes and fireworks, and positive steps should be taken for the welfare of such children as well as for improving the quality of their life.

to evolve steps consistent with the scheme laid down in M.C. Mehta case, to provide:

1. Compulsory education to all children either by the industries themselves or in coordination with it by the State Government to the children employed in the factories, mine or any other industry, organized or unorganized labour with such timings as is convenient to impart compulsory education, facilities for secondary, vocational profession and higher education;
2. apart from education, periodical health check-ups; and Nutrient food etc.;

The **Bandhua Mukti Morcha vs. Union of India** [7] case dealt with the issue of the release of bonded labourers especially from stone quarries from Haryana.

The Supreme Court appointed a committee to inquire into the conditions of the stone quarry workers. The committee reported that due to a large number of stone crushing machines operating at the site, the air was laden with dust making it difficult to breathe. Workers were forced to work and not allowed to leave the stone quarries. They did not even have potable water and were living in *jhuggies* (shanties) with stones piled one upon the other as walls and straw covering at the top that did not afford any protection against the sun and the rain, and which were so low that a person could hardly stand inside them. A few workers were suffering from tuberculosis. Workers were not paid compensation for injuries caused in accidents arising in the course of employment. There were no facilities for medical treatment or schooling for children.

The Court held:

It is the fundamental right of everyone under Article 21 to live with human dignity, free from exploitation. This right to live with human dignity enshrined in Article 21 derives its life and breath from the Directive Principles of State Policy and particularly clauses (e) & (f) of Article 39 & Articles 41 & 42 and at least, therefore, it must include protection of the health and strength of workers, men and women, and the children of tender age against abuse, opportunities and facilities for children to develop in a healthy manner and in conditions of freedom and dignity, educational facilities, just and humane conditions of work and maternity relief. These are the minimum requirements which must exist in order to enable a person to live with human dignity and neither the Central nor the State Government has the right to take any action which will deprive a person of the enjoyment of these basic essentials. Since the Directive Principles of State Policy contained in clause (e) & (f) of Articles 39, 41 & 42 are not enforceable in a court of law, it may not be possible to compel the State through the judicial process to make provisions by statutory enactment or executive fiat for ensuring these basic essentials which go to make up a life of human dignity but where legislation is already enacted by the State providing these basic requirements to the persons, particularly belonging to the weaker section of the community and thus investing their right to live with basic human dignity, the State can certainly be obligated to ensure observance of such legislation, for inaction on the part of the State in securing implementation of such legislation would amount to denial of protection under Article 21, more so in the context of Article 256 which provides that the executive power of every State shall be so exercised as to ensure compliance with laws made by the Parliament & any existing laws which apply in that State.

In the **ASIAD Construction Workers Case**[8] another Bench of SC had held that the State was under a constitutional obligation to see that there was no violation of the fundamental right of any person, particularly when he belongs to the weaker section of the community and is unable to wage a legal battle against a strong and powerful opponent who is exploiting him. The Central Government is, therefore, bound to ensure the observance of various social welfare, and labour laws enacted by Parliament for the purpose of securing to the workmen a life of basic human dignity in compliance with the Directive Principles of State Policy.

---

[7] AIR (1984) SC 802; 19843 SCC 161
[8] People's Union for Democratic Rights vs. Union of India: AIR 1982 SC 1473, (1982) 3 SCC 235

The State of Haryana must therefore ensure that mine lessees or contractors, to whom it is giving its mines for stone quarrying operations, observe various social welfare and labour laws enacted for the benefit of the workmen. This is a constitutional obligation which can be enforced against the Central Government and the State of Haryana by a writ petition under Article 32.[9]

The Supreme Court also issued various directions to the State and Central Governments and some of the important directions concerning health are the following:

- The Central Government and the Government of Haryana will immediately take steps for the purpose of ensuring that the stone crusher owners do not continue to foul the air and they adopt either of two devices, namely, keeping a drum of water above the stone crushing machine with arrangement for continuous spraying of water upon it or installation of dust sucking machine and a compliance report in regard to this direction shall be made to this court on or before 28th February 1984.
- The Central Government and the Government of Haryana will immediately ensure that the mine lessees and stone crusher owner start supplying pure drinking water to the workmen on a scale of at least two litres for every workmen by keeping suitable vessels in a shaded place at conveniently accessible points and such vessels shall be kept in clean and hygienic condition and shall be emptied, cleaned and refilled every day and the appropriate authorities of the Central Government and the Government of Haryana will supervise strictly the enforcement of this direction and initiate necessary action if there is any default.
- The Central Government and the Government of Haryana will immediately direct the mine lessees and the stone crusher owners to start obtaining drinking water from any unpolluted source or sources of supply and to transport it by tankers to the work site with sufficient frequency so as to be able to keep the vessels filled up for supply of clean drinking water to the workmen and the Chief Administrator, Faridabad Complex will set up the points from where the mine lessees and the stone crusher owner can, if necessary, obtain supply of potable water for being carried by tankers.
- The Central Government and the State Government will ensure that conservancy facilities in the form of latrines and urinals in accordance with the provisions contained in Section 20 of the Mines Act, 1950 and Rules 33 to 36 of the Mines Rules 1955 are provided.
- The Central Government and the State Government will take steps to immediately ensure that appropriate and adequate medical and first aid facilities as required by Section 21 of the Mines Act, 1952 and Rules 40 to 45-A of the Mines Rules 1955 are provided to the workmen.
- The Central Government and the Government of Haryana will ensure that every workman who is required to carry out blasting with explosives is not only trained under the Mines Vocational Training Rules, 1966 but also holds first aid qualification and carries a first aid outfit while on duty as required by Rule 45 of the Mines Rules, 1955.
- The Central Government and the State Government will immediately take steps to ensure that proper and adequate medical treatment is provided by the mine lessees and the owners of the stone crushers to the workmen employed by them as also to the members of their families free of cost and such medical assistance shall be made available to them without any cost of transportation or otherwise and the doctor's fees as also the cost of medicines prescribed by the doctors including hospitalization charges, if any, shall also be reimbursed to them.
- The Central Government and the State Government will ensure that the provisions of the Maternity Benefit Act, 1961, the Maternity Benefit (Mines & Circus) Rules, 1963, and the Mines Creche Rules, 1966, where applicable in any particular stone quarry or stone crusher are given effect to by the mine lessees and stone crusher owners.
- As soon as any workman employed in a stone quarry or stone crusher receives injury or contracts disease in the course of his

[9] ibid

employment, the concerned mine lessee or stone crusher shall immediately report this fact to the Chief Inspector or Inspecting Officers of the Central Government and/or the State Government and such Inspecting Officers shall immediately provide legal assistance to the workman with a view to enabling him to file a claim for compensation before the appropriate Court or authority and they shall also ensure that such claim is pursued vigorously and the amount of compensation awarded to the workman is secured to him.

- The Inspecting Officers of the Central Government as also of the State Government will visit each stone quarry or stone crusher at least once in a fortnight and ascertain whether there is any workman who is injured or who is suffering from any disease or illness, and if so, they will immediately take all necessary steps for the purpose of providing medical and legal assistance.
- If the Central Government and the Government of Haryana fails to ensure the performance of any of the obligations set out in clauses 11, 13, 14 and 15 by the mine lessees and stone crusher owners within the period specified in those respective clauses, such obligation or obligations to the extent to which they are not performed shall be carried out by the Central Government and the Government of Haryana.

In the case of **Mangesh Salodkar vs. Monsanto Chemicals of India Ltd.** (Writ Petition No. 2820 of 2003 decided by the Bombay High Court on 13th July, 2006), the issue concerned the conditions of work at the plants run by Monsanto Ltd. The company manufactured pesticides and it was alleged that a particular worker suffered from brain haemorrage because of the work environment. He survived but suffered major illnesses. He was paid Rs. 3 lakh by the company towards medical expenses but he filed a Petition in the high court. The court initially appointed a Commission headed by a retired judge of the high court. The Commission in turn summoned documents from the Factory Inspectorate and asked experts to look into the conditions of work at the factory. Some of the workers were also medically examined. During the pendency of the matter, the dispute between workers and employer was resolved with the employer agreeing to pay an additional Rs. 17. 80 lakh to the concerned employee and Rs. 7.40 lakh to some of the others who were affected. The Commission accordingly filed a report before the high court. Since the dispute between employer and employees was resolved the court was not called upon to determine that aspect. However, the court did go into some other aspects concerning the rights of employees to a safe work place, etc.

To begin with, the court held that the workers had a fundamental right to health at their work place. In addition it observed:

As this case demonstrates the absence of updated medical records results in a virtual denial of access to justice. In the absence of information, factory workers and all those who espouse the cause of workers cannot realistically attempt to redress the systemic failure on the part of the regulated industry to maintain regulatory standards.

The Court issued various directions including the following:

- The medical examination of workers which is to be conducted under Section 41E of the Factories Act, 1948 should be such as would enable an identification of diseases and illnesses which are a likely outcome of the process and material used in the factory;
- Copies of medical records of workmen must be handed over to them as and when medical examinations are conducted and the appropriate government will consider the issuance of suitable directions mandating the permanent preservation of medical records in the electronic form by factories engaged in hazardous processes;
- In respect of factories involved in hazardous processes, safety and occupational health surveys as required by Section 91A should invariably be carried out at the time of renewal of licenses, apart from other times.

Conclusion

The right to safe working environment has been recognized for the last 80 years. To begin with, it was only a recognition in principle. This was followed by recognition that if an injury was suffered at the workplace the employer was liable to pay compensation. Subsequently this was expanded to include occupational diseases. Over the years, the modalities and procedures required to fulfill this right have been fallen into place. These include regular medical examination, handing over medical reports to the workers and frequent inspection of the work premises. Certain health care aspects of the workers have also been recognized. These include the provisions under the ESI Act for providing free medical treatment to registered employees, and under the Factories Act for providing regular check ups, first aid kits and in certain circumstances also ambulance rooms and vans.

In India, occupational health is not integrated with primary health care, and it is the mandate of the Ministry of Labour, not the Ministry of Health. Enforcement is carried out through the Directorate of Industrial Safety and Health at the State levels operating through factory inspecting engineers and medical inspectors of factories. A DGFASLI (Director General of Factory Advisory Services and Labour Institutes) report (1998) reveals that there are 1,400 safety officers, 1,154 factory inspectors, and 27 medical inspectors in the country. The numbers are grossly inadequate. Enforcement agencies operate mostly in the organized sector neglecting the unorganized sector. There is an urgent need for confidence building for enforcement agencies.

On paper these laws appear very effective. Even otherwise, to a limited extent for the organized work force they do provide certain amount of succour. Even the Government employees have a number of schemes and provisions concerning medical benefits and care. But by and large they have been ineffective in dealing with the unorganized sector. To begin with, these laws do not apply to small scale industries. Also, implementation of these laws in many of the establishments to which they apply is also difficult. For instance, if the employer has not deducted or deposited the ESI contribution, the employee becomes disentitled to avail of the benefit. Similarly, many occupational diseases are not covered by the Act and at times it has become difficult to prove in courts that a disease occurred because of employment at a particular place. Courts role has also not been laudatory especially in recent times. For instance, in 2006, the Supreme Court held that a casual workman was not entitled to the benefit of the Workmen's Compensation Act.

Many large industries / public sector provide medical services but concentrate on curative Set-up neglecting occupational health. The Occupational Health Physician, where employed, also takes up mostly curative work and liaison work giving insufficient attention to occupational health. As a result there is under-diagnosis and under-reporting of occupational diseases. Moreover, the occupational hygiene activities, if undertaken, are carried out under safety, not under OHS. The majority of the working population belongs to the unorganized sector, which is not in the purview of current legislation in occupational health. With the advent of a new National Policy on Safety, Health and Environment at Workplaces and OSH Bill 2002, the Government is set to plug the loopholes and widen the coverage of occupational health services. An immediate goal of this draft national policy is to provide a statutory framework including the enactment of a general enabling legislation on OSH. The National Commission on Labour has formulated the provisions of the draft OSH Bill 2002.[10] The law will have general applicability at all work sites irrespective of the number of employees in those units, and be applicable to factories, mines, plantations, ports, construction sites, including the unorganized sectors, as well as the agricultural sector. The existing list of 29 hazardous industries is being expanded to 45 conforming to international norms. Employers are responsible for maintaining the health and safety of the workforce and to provide resources for the same.

[10] OSH Bill available at http://www.cec-india.org

Nine

Environment and Health

Adv. Vijay Hiremath

Introduction

The right to healthy, clean and pollution-free environment has its origin in the human right to health. because in order to have a healthy body one needs clean environment. There are, of course a number of additional reasons why we need of a good environment, namely conservation of natural resources, maintaining bio diversity and protecting wild life.

We address the following:

- Has the right to healthy environment vis a vis health been recognized in India?
- What has been the role of the judiciary and the legislature in furthering the right to healthy environment?

According to the Constitution of India it is the duty of the state to "protect and improve the environment and to safeguard the forests and wildlife of the country". It imposes a duty on every citizen "to protect and improve the natural environment including forests, lakes, rivers, and wildlife". A reference to the environment has also been made in the Directive Principles of State Policy as well as the Fundamental Rights. The Department of Environment was established in India in 1980 and in 1985, became the Ministry of Environment and Forests. The constitutional provisions are backed by a number of laws – acts, rules, and notifications. The EPA (Environment Protection Act), 1986 came into force soon after the Bhopal Gas Tragedy and is considered an umbrella legislation as it fills many gaps in the existing laws. Subsequently number of related laws have came into existence as the problems began rising, for example, the Handling and Management of Hazardous Waste Rules was passed in 1989.

In India, the judicial recognition of the fundamental right to healthy environment preceded the recognition of the right to health. A large chunk of public interest litigation in the last 20 years has revolved around environmental issues. In this Chapter, we are confining ourselves mainly to those judicial decisions that touch upon right to health care and not merely right to health.

Case Law

Healthy Environment, a Human Right

Municipal Council Ratlam vs. Vardichand and Ors[1] is a crucial case because for the first time the Supreme Court prescribed that in matters concerning public health financial inability was no ground for State authorities not to carry out their duties. The Apex Court held that,

...A responsible Municipal Council constituted for the precise purpose of preserving public health and providing better finances cannot run away from its principal duty by pleading financial inability. Decency and dignity are non-negotiable facets of human rights and are a first charge on local self-governing bodies. Similarly, providing drainage system – not pompous and attractive, but in working condition and sufficient to meet the needs

[1] AIR 1980 SC 1622

of the people – cannot be evaded if the municipality is to justify its existence... .

Ratlam is a town in Madhya Pradesh. The town had the Ratlam Municipal Council, as its local self governing body. Sanitation in Ratlam was pathetic as the drains overflowed. The municipality was oblivious to its obligation towards human well-being and was directly guilty of breach of duty and, of public nuisance and active neglect. The sub-Divisional Magistrate, Ratlam, was moved to take action under Section 133 CrPC to abate the nuisance by ordering the municipality to construct drains to wash the filth and stop the stench. The magistrate made the direction sought and scared by the prospect of prosecution under Section 188 IPC, for violation of the order under Section 133 CrPC, the municipality rushed from court to court till, it reached the Apex Court as the last refuge of lost causes.

The Sessions Court held the order as unjustified but the High Court of Madhya Pradesh upheld the order of the Divisional Magistrate, Ratlam. The Municipal Council, Ratlam argued that though it was their statutory obligation to build proper drains, there was financial inability. The Court held,

The plea of the municipality that notwithstanding the public nuisance financial inability validly exonerates it from statutory liability had no juridical basis. The criminal procedure code operates against statutory bodies and others regardless of the cash in their coffers, even as human rights under Part III of the Constitution have to be respected by the State regardless of budgetary provision. Likewise, Section 123 of the Act has no saving clause when the municipal council is penniless. Otherwise, a profligate statutory body or pachydermic governmental agency may legally defy duties under the law by urging in self-defence a self-created bankruptcy or perverted expenditure budget. That cannot be.

The Supreme Court also held that it was not just a matter of the health of a private individual; but the health, safety and convenience of the public at large was at stake.

The Supreme Court while passing the judgment in this matter partially modified the order of the magistrate and also asked the Municipal Council, Ratlam to carry out the following orders,

1. We direct the Ratlam Municipal Council (R1) to take immediate action, within its statutory powers, to stop the effluents from the Alcohol Plant flowing into the street. The State Government also shall take action to stop the pollution. The sub-Divisional Magistrate will also use his power under Section 133 CrPC, to abate the nuisance so caused. Industries cannot make profit at the expense of public health. Why has the magistrate not pursued this aspect?
2. The Municipal Council shall, within six months from today, construct a sufficient number of public latrines for use by men and women separately, provide water supply and scavenging service morning and evening so as to ensure sanitation. The Health Officer of the Municipality will furnish a report, at the end of the six-monthly term, that the work has been completed. We need hardly say that the local people will be trained in using and keeping these toilets in clean condition. Conscious cooperation of the consumers is too important to be neglected by representative bodies.
3. The State Government will give special instructions to the Malaria Eradication Wing to stop mosquito breeding in Ward 12. The sub-Divisional Magistrate will issue directions to the officer concerned to file a report before him to the effect that the work has been done in reasonable time.
4. The municipality will not merely construct the drains but also fill up cesspools and other pits of filth and use its sanitary staff to keep the place free from accumulations of filth. After all, what it lays out on prophylactic sanitation is a gain on its hospital budget.
5. We have no hesitation in holding that if these directions are not complied with the sub-Divisional Magistrate will prosecute the officers responsible. Indeed, this Court will also consider to punish for contempt in case of report by the sub-Divisional Magistrate of willful breach by any officer.

The Court also held that the State should be guided by the paramount principle of Art. 47 of the Constitution of India which states that,

improvement of public health should be one of the primary duties of the state.

The Bombay High Court in **Citizens Action Committee, Nagpur vs. Civil Surgeon, Mayo (General) Hospital, Nagpur and Ors**[2], put in detail the responsibilities of the Municipal Corporation, in marinating the civic hospital and the other basic amenities in the city. The high court in its order stated that,

We cannot but emphasise that the hospitals have their own role to play. Hospitals are the necessities of modern life and they have to respond to the needs of any growing city. Hardly any option can be speedy out or any excuse permissible so as to afford an alibi when the matters concern the authorities would bestow urgent attention on every facet of the problem of public health and effectively ... .

The Citizens Action Committee approached the Nagpur bench of the Bombay High Court asking the court to intervene as the overall condition of the civic amenities such as roads, sanitation and public health was deteriorating considerably.

The court issued notice to all the concerned authorities and asked them to file their say. Two fact finding reports of the citizens were also given to the court. The court largely based its finding on the reports and the affidavits filed by the citizens.

There were three hospitals that were being run by the state. Overcrowding in all these hospitals had reached dangerous levels. Trespassers and visitors also burdened the hospitals. Even the staff of the hospitals was housed in poor conditions and they were living in unhygienic conditions.

The court held that as per Art. 47 of the Constitution of India it is the duty of the state to provide for proper facilities for public health. The court set up an Investigative and Remedial Measures Suggestive Committee (I. R. M. S. C.) to look into the matter.

The High Court of Madhya Pradesh in **Hamid vs. State of M.P.**[3] held that the citizens have right to clean and safe drinking water. The court stated,

Under Article 47 of the Constitution of India, it is the responsibility of the State to raise the level of nutrition and the standard of living of its people and the improvement of public health. It is incumbent on State to improve the health of public providing unpolluted drinking water. State in present case has failed to discharge its primary responsibility. It is also covered by Article 21 of the Constitution of India and it is the right of the citizens of India to have protection of life, to have pollution free air and pure water... .

The court also held that the state was liable to pay for the damages caused by the consumption of the polluted water.

Hamid Khan a lawyer filed a petition before the High Court of Madhya Pradesh, regarding the quality of water supplied through the hand pumps in the district of Mandla. The water being supplied contained high amount of fluoride causing damages such as skeletal flurosis and dental flurosis to a number of people.

The High Court held

Under Article 47 of the Constitution of India, it is the responsibility of the State to raise the level of nutrition and the standard of living of its people and the improvement of public health. It is incumbent on State to improve the health of public providing unpolluted drinking water. State in present case has failed to discharge its primary responsibility. It is also covered by Article 21 of the Constitution of India and it is the right of the citizens of India to have protection of life, to have pollution free air and pure water...

The court also held that the people affected due to the contaminated water should be treated at the expense of the State. It also added that the State should bear the expenses of any surgery might be required.

---

[2] AIR 1986 Bom 136
[3] AIR 1997 MP 191

The State was also directed to closing of hand pumps where the water had excessive amount of fluoride and that a proper and safe drinking water facility should be put in place.

The Allahabad High Court in **Kamlavati vs. Kotwal and Ors**[4], ordered the brick klin owners to follow the norms laid down by the government very strictly and also ordered the government to set up a fund for the modernization of the brick kilns as the traditional brick klins were causing a lot of air pollution.

The Supreme Court in **Murli S Deora vs. Union of India and Ors**[5], recognized the harmful effects of smoking in public and also the effect on passive smokers, and in the absence of statutory provisons at that time, prohibited smoking in public places such as,1.auditoriums, 2. hospital buildings, 3. health institutions, 4. educational institutions, 5.libraries, 6. court buildings, 7. public office, 8. public conveyances, including the railways.

Conclusion

In the hundreds of cases dealing with the environment, our Courts have not really dealt so much with right to health care as the right to health and the impact of environment on health. While dealing with environmental issues the Supreme Court has developed a number of innovative doctrines such as 'polluter pays', 'public trust', 'reversal of burden of proof', 'preventive principle', 'trangenerational equity', etc. However, none of them directly deal with health care. Many might argue that as long as the environment is clean and this leads to the better health of the people it does not matter. as it is the result that counts. But the notion of the 'right to health', does not come clearly through these judgements. It is important to recognize this aspect, as it is of utmost important to put across to the common people and the executive that there is more than one reason to keep the environment clean. However, few of these judgements have asked the polluters to compensate the victims.

The orders of judiciary in the environment cases have made a difference to the environmental law scenario in the country and also in providing clean environment. In this 'development' era where 'Special Economic Zones' are, cropping up across the country it is important for the judiciary to play an proactive role in safeguarding the environment and also looking at the health aspects of the people living in this country.

---

4 MANU/UP/0785/2000
5 AIR 2002 SC 40, MANU/SC/0703/2001

Ten

Mental Health Care

Adv. Mihir Desai and Adv. Kamayani Bali Mahabal

Introduction

The mental health sector is governed by a law, the Mental Health Act, 1987 and not a national policy. The law leans heavily on institutionalised care, where ill persons can enter the institution of their own will, but cannot exit on their own volition. Some of the specific challenges faced by the mental health sector in India include the fact that with approximately 10 million persons requiring care, we have 0.2 psychiatrists per 1000,000 people, inadequate training capacity, poor or non-existent linkages between community and hospital- based care and weak institutional framework.

In this Chapter we deal with the following issues:

- What are the different laws that deal with mental health and mental health care?
- What are the significant issues dealt with by the courts concerning mental health care?

Under Section 328 of the Code of Criminal Procedure (CrPC) when an accused is unable to understand the trial due to unsoundness of mind it is mandatory on the magistrate to refer the accused for a medical examination. While the court is required to postpone the trial only if the accused is unable to understand the proceedings by reason of unsoundness of mind, the case law shows that the further inquiry on incapacity is not undertaken and when unsoundness of mind is established, the consequent incapacity is presumed and the trial postponed until the accused regains sanity. Section 330 of the CrPC provides that during the period of postponement, the 'undertrial of unsound mind' should either be released on a bond of safe custody from a relative or friend; or be kept in safe custody in a jail or a mental hospital. There is no guidance in the statute as regards when each of these options should be utilised. Consequently, an 'undertrial of unsound mind' can obtain the benefit of the less restrictive alternative of being released in the community provided he or she has a relative or a friend who is willing and able to offer security. The statute provides no outer limit for which the trial would remain postponed. The prison authorities are under an obligation to send a medical report every six months on the state of mind of the accused and this obligation is the only safeguard against indefinite confinement.

Mental health as an issue is a part of a number of laws but more particularly the following:

1. Matrimonial laws where certain kinds of mental illnesses are treated as grounds of divorce or for nullity of marriage;
2. Mental Health Act (earlier the Lunacy Act) which deals primarily with institutionalization of mentally ill persons.
3. Persons with Disabilities Act, which includes the issue of mental disability.
4. Laws dealing with contracts where contractual obligations are contingent upon the contracts having been entered into in sane state of mind.
5. Criminal laws where liability is diminished or extinguished if the person was of unsound mind at the time of committing the crime.
6. Many laws where occupying a position under the law is contingent upon the person being mentally sound.

Thus there are hundreds of laws that touch upon mental health at least in a peripheral way. However, this Chapter is confined to mental health care and not other related issues.

Persons suffering from mental illness have historically been treated as persons from whom the society needs to be protected. Thus, the earlier Indian Lunacy Act, and its reincarnation the present Mental Health Act have both dealt essentially with institutionalization of mental health care patients. The court cases concerning mental health care have also been mainly around conditions of these institutions.

Secondly, defining what is a mental illness has been a problem. Some acute cases are easy to define but a number of others depend not only on the development of medical science but also the way in which society deals with a particular issue. For instance, in 1851 Dr. Samuel Cartwright said that '*Drapetomania*' was a mental illness. Drapetomania was defined as tendency of black slaves to run away from their masters. Homosexuality was considered a psychological disorder till very recently and even now many doctors believe it to be so. There is a big debate currently on whether any condition can be called a psychological disorder as, according to many people, we have an image of how people should behave, and if they do not behave in that manner they are branded as having a disorder.

Matrimonial litigation is replete with cases where insanity is a ground for divorce. Many testamentary depositions or what are commonly known as wills are challenged on the ground that the person making it was not of sound mind. There are a number of instances where a person charged with a criminal offence has set up the defense of insanity. But all these cases are concerned with mental health and not mental health care, which is the subject matter of this Chapter.

Case Law

Right to Treatment

In **Dr. Upendra Baxi vs. State of Uttar Pradesh,**[1] the Supreme Court was called upon to enforce the human rights of the occupants of State Protective Homes for women. The Court ordered a medical panel to examine the inmates at the Agra Home and submit the report. The Report showed that 33 out of 50 inmates had varying degrees of mental disability and had not been examined at the time of admission to the Home. Despite this the Superintendent had released 14 of them without determining their mental state and with no money to cover even their train fare to their home towns. The Court recommended that psychiatric treatment be provided to the mentally ill inmates, for which the record of the time and place of the treatment should be maintained.

Rakesh Chandra Narayan vs. State of Bihar[2] was a case, which arose out of a letter written to the Chief Justice of India by two residents of Patna regarding conditions of mental hospital near Ranchi. It was a state run hospital directly under the Ministry. To begin with, the Court observed:

In welfare State—and we take it that the State of Bihar considers itself to be one such—it is the obligation of the State to provide medical attention to every citizen. Running of the mental hospital, therefore, is in the discharge of the State's obligation to the citizens and the fact that lakhs of rupees have been spent from the public exchequer (perhaps without or inadequate return) is not of any consequence. The State has to realise its obligation and the Government of the day has got to perform its duties by running the hospital in a perfect standard and serving the patients in an appropriate way. The reports and affidavits of the Government of Bihar and its officers (not the reports furnished to the Court by the judicial officers) have not given us the satisfaction of the touch of appropriate sincerity in action.

The Court initially issued the following directions:

1. In respect of each patient in the Ranchi Mansik Arogayashala the daily allocation for diet will be increased from the existing inadequate articles of that value shall be supplied to each patient.
2. Arrangements should be made forthwith to supply adequate quantity of pure drinking water to the hospital, if necessary, by engaging

[1] (1983) 2 SCC 308
[2] (1989) SUPP 1 SCC 644

water tankers to transport potable water from outside.

3. Immediate arrangements should be made for the restoration of proper sanitary conditions in the laboratories and bathrooms of the hospital.
4. All patients in the hospital who are not at present having mattresses and blankets should be immediately supplied the same within 15 days from today. Such of the patients who have not been given cots should also be provided cots within six weeks from today so that no patient shall be thereafter without a cot.
5. The ceiling limit at present in vogue in respect of cost of medicines allowable for each patient will stand removed, with immediate effect and the patients will be supplied medicines according to the prescription made by the doctors irrespective of the costs.
6. The State Government shall forthwith take steps to appoint a qualified Psychiatrist and a Medical Superintendent for the hospital and they should be posted and take charge in the Institution within six weeks from today.

The Chief Judicial Magistrate, Ranchi to whom a copy of this order will be forwarded by the Registry shall visit the hospital once in 3 weeks and submit quarterly reports to this Court as to whether the aforesaid directions given by us are being complied with.

There have been repeated allegations that the lady patients who have already been cured are not being released from the hospital. At one stage the explanation offered by the hospital authorities and the State administration was that the relations, even though notified, are not taking them back. The hospital is not a place where cured people should be allowed to stay. It is, therefore, necessary that there should be a rehabilitation centre for those who after being cured are not in a position to return to their families or on their own seek useful employment. The Committee shall therefore, take immediate steps to have a rehabilitation centre at a convenient place around Ranchi where appropriate rehabilitation schemes may be operated and the patients after being cured, irrespective of being male or female, if they are not being taken back by the members of their families could be rehabilitated. The funds made available to the Committee may be utilised for such purpose.

However, since not much improvement had taken place despite orders, finally in 1994 the Court[3] directed that an autonomous body be set up to manage and run this institution.

Human Rights Violations in Institutions

Sheela Barse vs. Union of India[4] dealt with children who were kept in jails across the country for 'safe custody' as allegedly they are physically and mentally retarded.

Court observed:

Meanwhile, there are a few matters which need our urgent directions. It seems that there are a number of children who are mentally or physically handicapped and there are also children who are abandoned or destitute and who have no one of take care of them. They are lodged in various jails in different states... .

...The State Governments must take care of these mentally or physically handicapped children and remove them to a Home where they can be properly looked after and so far as the mentally handicapped children are concerned, they can be given proper medical treatment and physically handicapped children may be given not only medical treatment but also vocational training to enable them to earn their livelihood. Those children who are abandoned or lost and are presently kept in jails must also be removed by the State Governments to appropriate places where they can be looked after and rehabilitated... .

...We would also ask the Director General, All India Radio and the Director General, Doordarshan to give publicity requesting non-governmental social service organisations to offer their services for the purpose of accepting these children with a view to taking care of them and providing for their

[3] (1994) 3 Supp SCC 374
[4] (1986) 3 SCC 632, Vide order dated 15.4.1986

rehabilitation in accordance with a hand-out to be sent by the Registrar of this Court.

Another case filed by **Sheela Barse**[5] dealt with children and women committed to jails as lunatics in Calcutta. The Supreme Court appointed a committee to visit the jails and give its report. Subsequent to this, the Court transferred the matter to the respective High Courts in India asking them to look into the matters.

In **Chandan Kumar Banik vs. State of West Bengal** [(1995) Supp. 4 SCC 505] the Supreme Court deplored the inhuman conditions of the mentally ill in the Mental Hospital at Mankundu in the District of Hooghli. The Court ordered for discontinuing the practice of tying up the patients with iron chains and ordered drug treatment for them.

The indifference of State and private authorities caused the tragic death of 26 inmates at Erwadi as they were tied to their beds on the night a fire broke out in August 2001.In the case of Death of 25 chained inmates in Asylum fire in TN., in **Re. vs. Union of India**[6] the issue of rights of inmates of mental asylum was raised. This petition sought directions for implementation of provisions of Mental Health Act, 1987 to prevent another mishap of the kind in mental asylum in Tamil Nadu.

In light of the provisions of Mental Health Act, Supreme Court issued following directions for its implementation:

(i) Every State and Union Territory must undertake a district-wise survey of all registered/unregistered bodies, by whatever name called, purporting to offer psychiatric/ mental health care. All such bodies should be granted or refused licence depending upon whether minimum prescribed standards are fulfilled or not. In case licence is rejected, it shall be the responsibility of SHO of the concerned police station to ensure that the body stops functioning and patients are shifted to government mental hospitals.

(ii) Chief Secretary or Additional Chief Secretary designated by him shall be the nodal agency to coordinate all activities involved in implementation of the Mental Health Act, 1987, the Persons with Disabilities (Equal Opportunities, protection of rights and full participation) Act, 1995 and National Trust for Welfare of Persons with Autism, Cerebral Palsy, mental Retardation and Multiple Disability Act, 1999. He shall ensure that there are no jurisdictional problems or impediments to the effective implementation of the three Acts between different Ministries or Departments. At the Central level, Cabinet Secretary, Government of India or any Secretary designated by him shall be the nodal agency for the same purpose.

(iii) The cabinet Secretary, Union of India shall file an affidavit in SC within one month from the date of this order indicating:

a) The contribution that has been made and that is proposed to be made under Section 21 of the 1999 Act which would constitute corpus of the National Trust.
b) Policy of the central Government towards setting up at least one Central Government-run mental hospital in each State and union Territory and definite time schedule for achieving the said objective.
c) National policy, if any framed under Section 8(2)9b) of the 1995 Act.
d) In respect of the States/UT that do not have even one full-fledged State Government-run mental hospital, the Chief Secretary of the State/UT must file an affidavit within one month from date of this Order indicating steps being taken to establish such full-fledged State Government-run mental hospital in the State/UT and a definite time schedule for establishment of the same.
e) Both Central and State Governments shall undertake a comprehensive awareness campaign with a special focus to educate people as to provisions of law relating to mental health, rights of

[5] Sheela Barse vs. Union of India (1993) 4 SCC 204
[6] (2002) 3 SCC 31

mentally challenged persons, the fact that chaining of mentally challenged persons is illegal and mental patients should be sent to doctors and not to religious places for treatment.

(iv) Every State shall file an affidavit stating:
   a) Whether the state Mental Health Authority under Section 3 of the 1987 Act exists in the State and if so, when was it set up.
   b) If it does not exist, the reason thereof and when such an Authority is expected to be established and operationalised.
   c) The dates of meetings of those Authorities, which already existed, from the date of inception till date and a short summary of the decisions taken.
   d) A statement that the State shall ensure that meetings of the Authorities take place in future at least once in every four months or at more frequent intervals depending on exigency and that all the statutory functions and duties of such Authorities are duly discharged.
   e) The number of prosecutions, penalties or other punitive/coercive measures is taken, if any, by each State under the 1987 Act.

In **Saarthak Registered Society and another vs. Union of India**,[7] as a continuation to the above order, the Supreme Court passed the following directions:

1. Every State and Union Territory shall undertake an assessment survey and file the report on the following aspects:
   a. Estimated availability of mental health resources including psychiatrists, psychologists, psychiatric social workers and nurses in both public and private sector
   b. Type of Mental Health Delivery System available in the State including available bed strength, outpatient and rehabilitation services
   c. An estimate of the Mental Health Services that would be required considering the population of the State and the incidence of mental illness
2. The Chief Secretary of each State and Administrator/Commissioner of every UT to file affidavit stating clearly-
   a. Whether any minimum standards have been prescribed for licensing of Mental Health Institutions in the State/UT and in case such minimum standards have been prescribed
   b. Whether each of the existing registered Mental Health Institutions in the State/ UT whether private or run by the State meet the basic minimum standards as on date of passing this order and if not, what steps have been taken to ensure compliance of licensing conditions
   c. Number of unregistered bodies providing psychiatric/mental health care exist in the State and whether any of them comply with minimum standards.
   d. Whether any mentally challenged person is found to be chained in the State.
3. The report on the Need Assessment Survey and affidavit was to be submitted to the Health Secretary, Union of India within a stipulated time. The Health Secretary was to compile them and present it to the Court.
4. Further Union of India was directed to:
   a. Frame a policy and initiate steps for establishment of at least one Central Government run Mental Health Hospital in each State
   b. Examine the feasibility of formulating uniform rules regarding standard of services for both public and private sector Mental Health Services
   c. Constitute a committee to give recommendations on the issue of care of mentally challenged persons who have no immediate relatives or who have been abandoned by relatives.

[7] (2002) 3 SCC 31

d. Frame norms for non-government organizations working in the field of mental health and to ensure that the services rendered by them are supervised by qualified/trained persons.

5. All State Governments were also directed to frame policy and initiate steps for establishment of at least one State Government run Mental Health Hospital in each State.
6. Two members of the Legal Aid Board of each State were appointed to make monthly visit to such institutions to help the patients and their relatives in applying for discharge if they have been fully discharged.
7. Two members of the Legal Aid and Judicial Officer would explain their rights to patients and their guardians at the time of admission to the institutions.
8. Form a Board of Visitors as required under the Mental Health Act to every State or private institution at least once a month.
9. Envisage a scheme for rehabilitation process for people who are not having any backing or support in the community.

In **Veena Sethi vs State of Bihar,**[8] a letter was sent to Justice Bhagwati by the free Legal Aid Committee on the basis on an article in a newspaper on 17/12/1981. It was registered as a petition under Art 32 [9] of the Constitution. The Legal Aid Committee, Jamshedpur, through its lawyer Veena Sethi, directed that all charges be dropped against 16 prisoners kept in the Hazaribagh jail for over 25 years because they were of "unsound mind". The Supreme Court said that there must be an adequate number of institutions for looking after mentally sick prisoners and that the practice of sending persons of unsound mind to jail for safe custody was not a healthy or desirable one because jail was not an appropriate place for treating those who were mentally ill. The Court directed the jail superintendent to have such mentally ill undertrials examined by psychiatrists every six months and submit a report to the District Judge. It said that if, as a result of such examination, it is found at any stage that the prisoner concerned had become sane; the District Judge should immediately order his or her release from the jail. The State government would provide the necessary funds for meeting the expenses of the journey to his or her native place and his or her maintenance for a period of one week, the court said. The state has to provide legal aid in such cases.

This case has also brought to the fore the cases of individuals who were ordered to be kept in detention after their trials were postponed, as they were incapable of defending themselves on ground of 'unsoundness of mind'. In all cases, the period of detention was longer than what might have been awarded if they had been punished for the offence with which they were charged. The case also showed that this indefinite duration confinement may have continued without remission unless the Supreme Court intervened.[10]

What needs to be understood here is that the provision of medical examination, as also of postponement, has been incorporated ostensibly to ensure that a person with psycho social disability is accorded a fair trial. What however is not appreciated is that the person with disability pays the cost of this fair process provision with the loss of liberty, which could be of indefinite duration.

This provision of safe custody does not subsist only in relation to 'insane undertrials'. A similar provision exists for 'insane acquittees'. Thus, when a court acquits a person on grounds of unsoundness of mind, acquittal does not mean discharge. The court can under Section 335 of the CrPC either release the 'insane acquittee' on security of a friend or relative or order the 'insane acquittee' to be kept in safe custody of jail or a mental hospital. Once again, release can be secured only if family support is available. The statute provides no guidelines on the periods for which 'insane acquittees' can be kept in a place of safe custody. Veena Sethi once again provided evidence on the indefinite nature of this confinement and the unwillingness of state authorities to order the release of 'insane acquittees'.

---

[8] Writ Petition (Cri) No 73 Of 1982

[9] Art 32 is the right to move the Supreme Court by appropriate proceedings for the enforcement of the rights

[10] AIR1983 SC 339

One of the most shocking cases was that of **Ajoy Ghosh vs State of West Bengal.**[11]Ajoy Ghosh was arrested in 1962 on the charge of murdering his brother. Subsequently, he was certified insane. After his mother died in 1968, there was no one to visit him. While he remained an undertrial, the trial judge and all the witnesses died. He could not be acquitted unless tried and since he was declared to be of "unsound mind" he could not be tried. Finally, in November 1999, 37 years after he first stepped into a prison, the Supreme Court ordered his transfer from the Presidency Jail in Kolkata to a home run by the Missionaries of Charity.

Since the bio- medical approach to mental health equates it with a disease, abnormality and danger, the law and practice in the area of health grounded on this approach generally aim towards prevention of disability and conditions in which treatment to cure disability is to be administered. The Mental Health Act of India is a classic example of this approach.

Electro Convulsive Therapy

It is a well-known fact that mental health institutions in India continue to rely on Electro-convulsive therapy (ECT), which is banned in most countries. In **S.P. Sathe vs. State of Maharashtra**[12], the Bombay High Court regulated the prescription of indiscriminate electric shocks to mentally ill persons. The directions included that reports be made whenever eletcric shocks were given by a prison psychiatrist.

A writ petition in the High Court of Bombay at Panaji challenged the practice of administrating ECT without anaesthesia at the Institute of Psychiatry and Human Behaviour (IPHB), Panaji, Goa.[13] The petition was filed on the basis of a complaint from a patient's relative recently committed to the IPHB for treatment. Patients at the IPHB were administered ECT without anaesthesia because no anaesthetist was available and the machine was non-functional and in disrepair. The IPHB administered a minimum of 200 procedures a month, with staff members holding the patient down during the procedure. The practice was barbaric, inhuman and hence in violation of Article 21 of the Constitution; in violation of Section 81 (Chapter VIII) of the Mental Health Act, 1987, providing that no mentally ill person be subjected during treatment to indignity or cruelty. The use of anaesthesia without anaesthesia could lead to patient discomfort, fractures of the spine and long bones, and dislocations particularly of the jaw. The ECT was also being administered without the patients' informed consent. The petitioner filed the petition on behalf of patients and their relatives, since patients were in no position to approach the court, and relatives were reluctant to come forward, given the stigma attached to mental illness.[14]

The Institute started modified ECT in 1988. However, it stopped the practice in 1992 after the anaesthetist left. In 1995, the government instructed it not to fill up the post, and that the senior resident in anaesthesia attached to the Goa Medical College would be at their disposal. On September 22, 1998, the Goa Medical College deputed an anaesthetist twice a week to the Institute.According to Dr. John Fernandes, Director of IPHB, *"Since the inception of the establishment of the Institute in 1980, (it) has been treating patients requiring ECT with direct form without administering anaesthesia without any hazards. Our procedures have been free of incidents of fractures. ECT is conducted after taking the consent of patients or, when appropriate, their relatives"*. The director attached a list of 11 mental hospitals in India, practising only direct ECT, and eight practising both.

Direct ECT is not a medically indicated choice but a practice based on non-medical grounds such as non-availability of anaesthetists and the accompanying infrastructure. Lack of such facilities are due to socio- political reasons and not germane to sound medical practice and procedure.

At least two of the hospitals listed by the respondent have been severely criticised by the Supreme Court.

---

[11] Ajoy Ghosh Story, Justice A.S Anand (Rtd), The Tribune, Dec 20, 2003
[12] Writ Petition No 1537 of 1984, Bombay
[13] Writ Petition 357/ 98 delivered on October 14, 1998.
[14] ibid

Also, the High Court of Maharashtra (**Shukri vs. State of Maharashtra, 1989,** regarding conditions in the Central Institute of Mental Hygiene and Research, Yervada, Pune) stated:

"Hospital authorities should review the effects of direct ECT on the patient and should decide whether the method should be continued in view of the fright taken by the patients. Modified ECT is recommended."[15]

In 1988, Shukri from Bombay filed a writ petition in the Bombay High Court.[16] He complained that his mother, who was an inmate of Yeravada Mental Hospital, died due to negligence of the staff. The High Court appointed a committee to look into the affairs at the Hospital. The Mahajan Committee was appointed to look into the affairs of the Central Institute of Mental Hygiene and Research, Yerawada, Pune; and to submit a report about the improvements to be carried out in the Hospital. The Committee had several meetings and visits to the Hospital, and came out with the Mahajan Committee Report on August 5, 1989. The Report has taken up 8 specific aspects: environment; (ii) patients; (iii) staff for the care of the patients; (iv) method of treatment; (v) conditions at the hospital; (vi) internal control; (vii) orientation; and (viii) arrangement for specialised treatment.

Summary of Mahajan Committee Recommendations:

The following is a summary of all the recommendations of the Mahajan Committee, contained in Chapter X of the Report:[17]

(i) Environment:
Immediate steps to be taken to improve the environment conditions by creating a more humane and pleasing environment wherein the patients can live with human dignity. The dilapidated buildings to be repaired or reconstructed. Along with additional dormitories or wards .The essential amenities, such as drinking water and toilet facilities to be provided inside the wards.

(ii) Patients:
No patient should be made to do menial work, which is to be done by hospital employees. No patient should be subjected to cruelty. Drab and obnoxious clothing and clothing used by other patients should not be given to patients for use. Patients should be provided with a cot, mattress and sufficient linen, which is frequently changed. Patients should be given a bath daily and should be provided with toiletries. Attention should be paid towards the cleanliness of patients. Medical examination of patients should be conducted on a weekly basis. A Wholesome diet should be provided to patients.

(iii) Staff:
The Staff should be provided with orientation and regular in-house training and should be assigned duties, and duty charts to be accordingly prepared. Medical officers on duty should make rounds of hospitals and record their findings in day record book. They should be available in the duty room in the hospital. Observations about patients should be recorded in the night round book. Employees treating patients in a cruel manner should be strictly dealt with. Special arrangements should be made for emergency cases.

(iv) Method of Treatment:
The individual treatment plan should be prepared by qualified professionals for each patient. Medical professionals should constantly review this individual treatment plan. Patients should undergo a comprehensive physical and mental examination on admission and appropriate treatment for physical illness should be available in mental health institutions.

The case file and medical record of the patient should be maintained. E.C.T. (Electro Convulsive Therapy) should be given in modified form and in decentralised units. Patients undergoing E.C.T.

---

[15] Indian Journal of Medical Ethics April, June 1999, 7(2)
[16] Petition (No. 7560) in Bombay High Court in 1988.
[17] Mahajan committee report available at http://www.camhindia.org (accessed on April 10th 2007)

should not witness shock treatment received by other patients. Code of conduct prescribed in the manual with regard to duties and responsibilities of medical and nursing staff should be strictly enforced. Sufficient number of clinical psychologists should be appointed.

(v) Degrading Condition:
There should not be more than six patients in a room. Each patient should be allocated a minimum of 56 ft. floor space. Wards should be periodically treated for pest control. Sufficient toilet and lavatory facility should be provided inside wards, and such facility should ensure privacy to patients. Bathing facilities should be provided in a manner so as to ensure privacy. Both hot and cold-water facility to be provided. Patients should be provided with proper dining facilities and the kitchen should be properly maintained and diet should be constantly changed. The co-operative society of the staff should not be awarded contract for supplying provision or any other material. The system of keeping patients locked up should be discontinued.

(vi) Orientation:
A Comprehensive orientation programme should be conducted for staff at all levels and the syllabus of the training course should include legal provisions and provisions relating to functioning and management of mental health institutions. Short term and long-term courses to be conducted. These courses are necessary to acquaint the staff with new approaches in treating patients with mental disorder. Intensive training should be given to the staff to ensure that the staff will perform their respective jobs efficiently. The role of psychiatrists, clinical psychologists and psychiatric social workers should be defined and co-ordinated. Workshops and training programmes should be conducted for specialists in which their respective roles should be explained.[18]

Even though the petition was disposed of, Malati Ranade presented substantial evidence in her letters dated 25.7.95 and 26.2.96 to the fact that the 'State Mental Authority and Inspector's Board' was a total myth, and that the Government had failed to do its duty towards the mental hospitals. She wrote letters and sent out circulars, and privately circulated several papers to peers and others. She questioned the inability of the State government to implement the Mental Health Act, 1987 [MHA] within the given time period of two years, thereby proving the invalidity of statements made in the Judgment -No.3128 of Dec. 1995 (pages 5 and 6). She monitored the process by which the mental health authorities were managing the issue by keeping article clippings, official letters, etc. She pointed out the errors, inaccuracies, denials and contradictions in the government response and follow up actions. She pointed out how the Visitor's book never reflected their visits for so many years. The Visitor's committee was not even aware of their mandate. Though Malati Ranade urged instruments viz. WHO, to look into the matters, nothing changed. The Government and the Court 'closed' the matter by delivering the final judgement in 1998 disposing of the case.[19]

Conclusion

The Mental Health Act, 1987 does not lay down specific guidelines to ensure minimum standards in the mental health institutions. As a consequence, a number of public interest litigations have been filed by concerned citizens and organisations drawing the attention of the Supreme Court to the appalling conditions that generally prevail in mental health institutions.

In **Rakesh Chandra Narayan vs. State of Bihar,**[20] the Supreme Court found the conditions in the Ranchi Mental Hospital to be shocking and inhuman and therefore appointed a committee to ensure proper functioning and management of funds. The Court also gave directions for mental health institutions to be modeled on the lines of the National Institute of Mental Health and Neurosciences(NIMHANS) at Bangalore. Similarly, **in B.R Kapoor vs. Union of India**[21] the Supreme Court recommended that the hospital

[18] ibid
[19] ibid
[20] Writ Petition (C) No 339 OF 1986
[21] Writ Petition (Cri) No 1777-1778 OF 1983

management be taken over by Union of India from the Delhi Administration.

Section 81(2) of the Mental Health Act bars a "mentally ill person" under treatment to be used for purposes of research except with his consent; if he is incompetent to provide such consent, the consent of his guardian is required. The statute thus allows a mentally ill person to be used as a guinea pig, since the guardian could well be the superintendent of the psychiatric hospital.

Worse, a person wrongfully admitted into a psychiatric hospital cannot engineer her own exit unless she has external assistance. Section 81(3) does prohibit the interception of correspondence of an inmate. However, this prohibition is not absolute and can be breached if the communication is regarded to be prejudicial to the treatment of the ill person.

The Mental Health Act 1987 has not been premised on the rights of persons with psychosocial disability. A rights based law would unequivocally accept the humanity of the rights holder and allow her opportunity to assert it. Constraints would be the exception and freedom the rule. It is only recently that the Courts have started looking into the issue of mental illness from the point of view of the mentally ill. It may still take more than a decade before a full a fledged understanding of rights of mentally ill develops. The right to health and access to medical services for persons with mental illness has evolved to some extent. However, the law is relatively underdeveloped in respect to a broader right to health for persons. For example, questions of availability, affordability, and accessibility of health services, and participation in planning of health policies by persons with disabilities have yet to form an important part of National and State health policies and programmes and related arrangements for the delivery of health services

Even today, mental illness is seen as a uniform medical problem without adequate recognition of the various kinds and degrees of mental illnesses. The law needs to deal with these disabilities by understanding the distinctive nature of each one of them. The law is also underdeveloped in its understanding and recognition of the various levels of autonomy that mentally disabled persons may be able to exercise.

Eleven

Reproductive Rights

Adv. Vijay Hiremath and Adv. Kamayani Bali Mahabal

Introduction

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence [ICPD, 1994].

In this chapter we try to seek answers to the following questions

- Have reproductive rights been recognized in India?
- What has been the approach of the courts towards reproductive rights?
- In the wake of support to the population control measures and the falling female child sex ratio, what is the approach of the courts?
- In what way have clinical research and trials have affected reproductive rights?

Pregnancy, childbirth and the post partum period are one of the riskiest stages of a woman's life. Every year over 1, 30,000 Indian women lose their lives in pregnancy and childbirth. The right to life can be extended to include the reproductive right of mothers to go safely through pregnancy and childbirth. However, this right has not been explicitly guaranteed, though as mentioned earlier, the Indian Constitution does make reference to maternity related benefits.

Safe abortion services have been mandated to be available to women in India since 1971 when the Medical Termination of Pregnancy (MTP) Act came into force. Earlier, because abortion was illegal, it was practised in a clandestine manner. The passing of the Act made medical termination of pregnancy legal, with certain conditions for safeguarding the health of the mother. This law guarantees the right of women in India to terminate an unintended pregnancy by a registered medical practitioner in a hospital established or maintained by the Government or a place being approved for the purpose of this Act by the Government. According to Section 3 of the Act, the pregnancy can be terminated: As a health measure when there is danger to the life or risk to physical or mental health of the women; on humanitarian grounds - such as when pregnancy arises from a sex crime like rape or intercourse with a lunatic woman, etc. and on Eugenic grounds - where there is a substantial risk that the child, if born, would suffer from deformities and diseases or because pregnancy has resulted from a contraceptive failure.

Although there are many contraceptives available in India female sterilisation is the most widely used contraceptive method in India. Conservative estimates put the numbers that will conceive even after undergoing tubectomy at around 25,000. Many more women face severe complications like wound infection or abdominal adhesions. The rights approach may be applied to female sterilisation and there are examples and precedents in various judgements of the Supreme Court of India.

In spite of the various schemes of the government at the central and state level reproductive rights continues to be a vulnerable issue within women's

rights. The two-child norm is usually seen as an attractive method to reduce 'alarming population growth' in India. The two child norm violates the reproductive right of women and couples to decide on the number and spacing of their children. The two child norm also violates the right to equality (a fundamental right) and is also leading to sex pre-selection and decline in sex ratio. *Beyond Numbers*, a study of the norm's impact in Madhya Pradesh by the women's group SAMA, documents a number of cases of women and dalits being removed from local office for not adhering to this norm. Moreover, to stay in office, husbands were forcing wives to have abortions or to give away their third children for adoption. There were also instances of men divorcing or deserting their wives and insisting that their third child was not their own.

The most frightening aspect of the two-child norm is the way it reinforces son preference and the practice of sex-selective abortion, much as the one-child policy has done in China. India's 2001 Census revealed a shocking decline in child sex ratios in many areas of the country, the lowest being 798 in Punjab. In Delhi, one of the country's most prosperous areas, there were only 716 girls born for every 1000 boys between January and June 2006. Given the ideology of son preference in the country a vigorous pursuit of the two-child norm is an invitation to sex-selective abortion.[1]

Though in the last few years laws have been enacted and judgements have been delivered by the Apex Court and the various high courts in the country, reproductive right has not been recognized as a right statutorily. The courts also have given conflicting judgements on the issue.

Case Law

Coercive Population Policy and its Acceptance in Courts

In **Javed vs. State of Haryana and Ors**[2], more than 200 writ petitions and high court appeals were consolidated into one case against the State of Haryana and the Union of India, which the Court treated as a PIL even though it was not filed as such. The litigants challenged the constitutionality of a coercive population control provision in the Haryana Panchayati Raj Act of 1994 (the Haryana Provision) that governs the election of panchayat (village council) representatives in Haryana. The Haryana Provision disqualifies "a person having more than two living children" from holding specified offices in panchayats. The objective of this two-child norm was to popularize family planning—the implication being that the restrained reproductive behavior of elected leaders would be a model for other citizens to follow [Buch, 2005]. The issues raised before the court were: Is the classification arbitrary? I Is the provision discriminatory and does it violate Article 21 of the Constitution of India?

The Apex court upheld the provision, disqualifying the persons having more than two children to contest election at panchayat level or to hold any post. In its judgement the Supreme Court held

We are clearly of the opinion that the impugned provision is neither arbitrary nor unreasonable nor discriminatory. The disqualification contained in Haryana Act seeks to achieve a laudable purpose - socio-economic welfare and health care of the masses and is consistent with the national population policy. It is not violative of Article 14 of the Constitution.

The court held that the classification is intelligible and is not arbitrary or discriminatory. and stated in its order

The disqualification enacted by the provision seeks to achieve the objective by creating a disincentive. The classification does not suffer from any arbitrariness. The number of children, viz., two is based on legislative wisdom. It could have been more or less. The number is a matter of policy decision which is not open to judicial scrutiny.

Regarding the Article 21, the court was of the opinion that the controversial provision was not

[1] For more information on womens health rights see Indian Women's Health Charter, March 2007 available at www.phm-india.org
[2] AIR 2003 SC 3057

violative of the Constitution of India and nor did it violate the principles of reasonable procedure, laid down in Mrs. Maneka Gandhi vs. Union of India and Anr.

Giving the China example of the compulsory one child policy the court held,

India being a democratic country has so far not chosen to go beyond casting minimal disincentives and has not embarked upon penalizing procreation of children beyond a particular limit. However, it has to be remembered that complacence in controlling population in the name of democracy is too heavy a price to pay, allowing the nation to drift towards disaster.

The Javed judgement has been a big setback for rights activists, because high court judges around the country will use this precedent to uphold two-child norm.

Maharashtra has gone further by including a provision in the Maharashtra Water Resources Regulatory Authority Act 2005, passed in April, that lays down that people with more than two children will have to pay one and half times the normal water charges for irrigation and drinking water. This step, the State feels will "promote family planning".

Failed Sterlisation and Medical Negligence

Female sterilisation is the mainstay of contraceptive methods in India. Every year over four million female sterilisation operations are conducted in the country. Like all surgical procedures, female sterilisation, despite being a relatively low-risk procedure, has its attendant risk and failure rates. According to international authorites, the failure rate, i.e. the chance of becoming pregnant after the operation is around one in 200, the rate of complication around one in 100 [Rotimi et al.][3] and the risk of death around three in 100,000 procedures [Chapron et al, 1998].[4] According to these estimates, there is a possibility of over 20,000 failures, 20,000 women with complications and about 150 deaths due to these operations. Doctors often justify the shoddy treatment of women at sterilisation camps by referring to the pressure of targets that they have to fulfil or the lack of time. The accountability to the employer (the government) in terms of the various pressures has to be balanced against the ethical responsibility towards the individual patient. Besides ethical principles, the consequences of poorly conducted operations have legal dimensions as well. Indian courts have admitted cases of tubectomy failure and deaths and have taken steps to compensate women both for medical negligence and fixed accountability of the state for negligence of the doctor in cases of failure as well as tubectomy deaths.

In **State of Haryana vs. Smt. Santara**[5] in a judgement delivered in 2000, the Supreme Court upheld the judgement of the High Court awarding compensation to Mrs. Santara, who gave birth to a daughter in spite of a sterilization operation carried on her earlier. This is one of the cases of negligence during the sterilization operations. A poor labourer woman, who already had many children and had opted for sterilisation, became pregnant and gave birth to a female child in spite of the sterilisation operation that obviously, had failed. Smt. Santra, the victim of the medical negligence, filed a suit for recovery of Rs.2 lakh as damages for medical negligence, which was decreed for a sum of Rs.54, 000 with interest at the rate of 12 per cent per annum from the date of institution of the suit till the payment of the decretal amount. Two appeals were filed against this decree in the court of the District Judge, Gurgaon and were disposed of by Additional. District Judge, Gurgaon, by a common judgment dated 10.5.1999. Both the appeals – one filed by the State of Haryana and the other by Smt. Santra were dismissed. The second appeal filed by the State of Haryana was summarily dismissed by the Punjab and Haryana High Court on August 3, 1999. A special leave petition was filed before the Supreme Court in this regard by Haryana.

[3] Rotimi AK, Eedarapalli P. Female Sterilisation, available at http://www.sexualhealthmatters.com/v2iss2/article4.html (accessed on April 18, 2007).

[4] Chapron C, Querleu D, Bruhat MA, et al. Surgical complications of diagnostic and operative gynae-cological laparoscopy: a series of 29,966 cases. Hum Reprod 1998;13:867-72.

[5] AIR 2000 SC 1888

The sterilisation operation was performed on her and a certificate signed by the medical officer, General Hospital, Gurgaon. to that effect was also issued to her on February 2,1988. Smt. Santra was assured that a full, complete and successful sterilisation operation had been performed upon her and she would not conceive a child in future. But despite the operation, she conceived. When she contacted the Chief Medical Officer and other doctors of the General Hospital, Gurgaon, she was informed that she was not pregnant. Two months later when the pregnancy became apparent, she again approached those doctors who then told her that her sterilisation operation had not been successful. Dr. Sushil Kumar Goyal, who was examined as DW-2, stated that the operation related only to the right fallopian tube and the left fallopian tube had not been touched, that is, 'complete sterlisation' operation had not been performed. She requested an abortion, but was advised that having an abortion would be life threatening for her. She ultimately gave birth to a female child. Smt. Santra already had seven children and the birth of a new child put an unnecessary burden on her. The doctors and the hospital authorities denied any kind of negligence in the sterilization operation. In the course of suit it was proved that only the left fallopian tube had been closed and the right one left untouched.

The Court held that as the sterilization operation was conducted under a government scheme the state was vicariously liable for the failure and the additional burden the family would face due to the birth of the child and held that the state was liable to pay to compensation to the mother as birth of one more girl has lead to the additional burden on the family.

In the case of **State of Punjab vs. Shiv Ram and Ors**[6], the Apex Court awarded compensation to the respondent in a case of failed sterilization operation, but it overturned the order of the lower court and the High Court and absolved the State Government, the hospital authorities and the doctors of negligence in performing the operation. The Court stated in its order that, none of the methods of female sterilization are foolproof and that no prevalent method guarantees 100 per cent success. A suit was filed against the lady surgeon who was in the State Government's employment at the relevant time, for recovery of damages to the tune of Rs. 3, 00,000 on account of a female child having been born in spite of a tubectormy being perfomed on the wife earlier According to the aggrieved couple, they already had a son and two daughters from the wed-lock lasting over 17 years. In response to a publicity campaign carried out by the Family Welfare Department of the appellant-State, the wife with the consent of husband, underwent a sterilization operation on August 1, 1984. A certificate in this regard bearing mark of identification No. 505, duly signed by the lady surgeon who performed the said surgery, was issued to her. She was given a cash award of Rs. 150 as an incentive for the operation. On October 4, 1991, respondent No. 2 gave birth to a female child. After serving a notice under Section 80 of the Code of Civil Procedure, a suit for recovery of damages was filed on May 15, 1992 attributing the birth of the child to carelessness and negligence of the lady surgeon. The plaint alleged *inter alia* that the respondents considered abortion to be a sin and that was why after knowing of the conception they did not opt for abortion.

The suit was decreed for Rs. 50,000 with interest and costs. The decree for compensation passed by the trial court has been upheld by the first appellate court. The second appeal preferred by the State has been summarily dismissed.

The State argued that it was not against the granting the compensation to the wife as they were poor but the state wanted the legality of such suits to be argued as many cases were being filed regarding failed family planning operations before the civil courts as well as the consumer forum.

In its order the court discussed the various methods of sterilization in detail and also reiterated the principles regarding medical negligence. The court came to the conclusion that, the cause of action for claiming compensation in cases of failed sterilization operation arises on account of negligence of the surgeon and not on account of

[6] AIR 2005 SC 3280

child birth. Failure due to natural causes would not provide any ground for claim. It is for the woman who has conceived the child to go or not to go for medical termination of pregnancy. Having known about the conception in spite of having undergone sterilization operation, if the couple opts for bearing the child, it ceases to be an unwanted child. Compensation for maintenance and upbringing of such a child cannot be claimed. Hence the Apex Court pointed out that the judgements passed by the high court and courts below cannot be sustained. Since the state had already stated that it was not against the compensation awarded to the women, the court held that if the compensation has been paid to the victim it should not be taken back from her. This judgement has changed the course of judgements in the cases regarding failure of sterilization operations.

In a similar case of failed sterilization operation in the **State of M.P. vs. Smt Sundari Bai and Anr**[7], the Madhya Pradesh High Court denied compensation to the women who gave birth to girl after six years after the sterilization operation. Sundari Bai gave a birth to female child. She claimed Rs. 50,000 as compensation as she was poor and had now to raise another child. The doctors in this case claimed that due to the peculiar condition of the respondent the fallopian tube had not been cut and tied and she had been advised not to do any strenuous work and have sexual intercourse for some time. The doctors denied that there was any kind of negligence in this case. The Trial Court held that there was negligence on the part of the lady doctor as she did not cut the fallopian tubes and merely "tied" them by adopting "ligation method". The compensation of Rs. 50,000 with interest at the rate of 6 per cent per annum has been awarded.

Allowing the appeal the high court in its judgement stated that,

A doctor does not give a contractual warranty. He is not an insurer against all possible risks. He or she does not provide insurance that there would he no pregnancy after sterilisation operation. As demonstrated above there is a chance of sterile being turned into fertile even after the operation has been done with due care and caution. A doctor is not liable in negligence because someone of grater skill and knowledge would have prescribed different treatment or "operated in a different way". She has to show only a reasonable standard of care. She cannot be held guilty for error of judgment. Considerable deference is paid to the practices of the professions (particularly medical profession) as established by expert evidence and the Court should not attempt to put itself in the shoes of the surgeon or other professional man. In the present case the plaintiff had two sons only. A female baby was born to her after six years. She should accept her with grace as gift of God. The parents are primarily liable to give birth to this child. They should not hold the doctor liable when they have been blessed with this baby. She should not have a feeling that she is an unwanted child. The birth of this baby should be considered a blessing and cause for rejoicing. A healthy female baby after the two sons, a lovely creature, must have brought decency, discipline and sobriety in the family.

And thus reversed the judgement passed by the trial court.

Achutrao Haribhau Khodwa vs. State of Maharashtra and Ors[8] was one of the worst cases of medical negligence especially in a sterilization operation. Chandrikabai the victim in this case had got herself admitted in the Civil hospital at Aurangabad, on July 10, 1963. Chandrikabai delivered a male child on July 10, 1963. As she had got herself admitted to this hospital with a view to undergoing a sterilization operation after the delivery, the operation was duly performed. Soon thereafter Chandrikabai developed high fever and also had acute pain, which was abnormal. As the condition of Chandrika bai worsened her husband approached the doctor Dr. Divan who was not from the gynaecology department but was from the same hospital. Dr.Divan suggested that the sterilization operation, which was done, should be opened up. But the doctors who performed the operation did

[7] AIR 2003 MP 284
[8] (2004) 3 CAL LT 609(HC)

not take the advice. The condition of Chandrikabai further deteriorated and on July 19, 1963, Dr. Divan, called by the husband of Chandrikabai opened the sterilization operation and found that a mop (towel) had been left inside the body of Chandrikabai when the sterilization operation was performed. The mop was removed and the pus was drained out. Yet the condition of Chandrikabai did not improve and she passed away on July 24, 1963.

Chandrikabai was a teacher, and claiming that there was loss of income for the family due to the death of Chandrikabai which was caused due to negligence, a suit for damages in Rs. 1,75, 000 was filed against the government of Maharashtra and also against the doctors who had performed the sterilization operation. The issues raised by the civl court were:

1. Was there enough proof that the doctor performed the operation without due care, attention and caution and in the most negligent manner and that a mop was left in the abdomen of the deceased Chandrikabai during the first operation, due to negligence of the doctor. The court also enquired whether the mop remaining inside the body of Chandrikabai during the first operation, caused the severe pain leading to her death.
2. Was there proof that doctor did not take proper care of Chandrikabai in the post operation stage and did it prove that there was mismanagement and careless behavior in the hospital and negligence resulting in the death of Chandrikabai?

At the end of the trial court did not rely upon the evidence of the experts examined because it came to the conclusion that the original documents and case papers had been filed late, some relevant entries had also been tampered with and it was only the typed papers, which were copies of the tampered documents, which were supplied to the respondents' expert witnesses for their opinion. The trial court passed a decree for Rs.36, 000.

An appeal was filed before the high court by the State of Maharashtra and also the respondent doctors. After going through all the evidence, the high court through its 300- page judgment came to the conclusion that it was difficult to hold that anything that was done during the sterilization operation, or thereafter, had definitely caused the death of Chandrikabai. While, holding that doctor had definitely been negligent in leaving a mop inside the abdomen of Chandrikabai, it held that the appellants had failed to prove that the negligence of leaving the mop inside the abdomen had caused the death of Chandrikabai. It, therefore, concluded that none of the respondents could be held liable for negligence. It, accordingly, allowed the appeals and dismissed the suit.

In an appeal filed by the husband of the Chandrikabai before the Supreme Court, the vicarious liability and the negligence of doctors was discussed in detail and at the end of the appeal the Court came to the conclusion that the state was vicariously liable for the negligence of its doctors and restored the order passed by the trial court in awarding compensation to the husband of Chandrikabai.

In **Murari Mohan Koley vs. The State and Anr**[9], where criminal prosecution was lodged, on the death of the women after a sterilization operation, the high court refused to discharge the accused and held that whether there was negligence or not would have to be proved through a trial. In this case the sub-divisional magistrate had taken cognizance of a complaint filed against the petitioner for causing miscarriage and also for destruction of evidence. The petitioner moved before the high court of Calcutta for setting aside the order of the sub divisional magistrate.

The petitioner was working at the Family Planning department of the Howrah General hospital and due to his qualification was also allowed to do private practice and had a clinic registered under the Medical Termination of Pregnancy Act, known as the 'Life Care' nursing home.

Sujit Mondal the complainant in this case had a daughter aged about six months and his wife Jhuma Mondal again conceived. In September 26, 2001, he got her examined by Dr. Murari Mohan Koley and as per his advice, he got her admitted in Life Care Nursing Home on October 15, 2001 at

[9] (2004) 3 CAL LT 609(HC)

4.30 pm. for abortion and there was an agreement for payment of Rs. 1000. Later the same evening Dr. Koley informed the complainant that his wife was serious and she would have to be kept in the nursing home for further five days and an additional amount of Rs. 5000 would have to be paid. The condition of the wife of the complainant further deteriorated and she started bleeding profusely. Dr. Koley at that time told the complainant that his wife would have to be shifted to Howrah General Hospital. Accordingly at about 7 pm, Jhuma Mondal was admitted to Howrah General Hospital and at about 9.30 pm she died.

As per the report of the post-mortem held on October 17 at Medical College and Hospital, Kolkata, two injuries were found on the two sides of the uterus and one U.D. case was started by Howrah Police (Howrah Police Station Case No. 345 dated 16.10.2001). The police also opened the Shibpur P.S. Case (No. 245 of 2001 dated 06.11.2001) under Section 314[10] of the Indian Penal Code against the petitioner on the basis of the complaint filed by Sujit Mondal.

The petitioner had filed an application before the high court and contended that there was no negligence on his part and secondly that there was no sanction taken to prosecute him under the Medical Termination of Pregnancy Act as per the requirements.

Rejecting the application of the petitioner the court held

I am rather prompted to hold that to get the protection of Sub-section (1) of Section 3 of Act of 1971, the petitioner as a medical practitioner has to prove that he has done the same in good faith which may also include the omissions, but this is not the appropriate stage where the Court should go on embarking upon by way of enquiry as to whether it was done in good faith or otherwise and it is required to be left to be decided by the trial Judge at its appropriate stage in the trial

Thus the court refused to intervene in the matter and held that whether and act was done in good faith or not and also whether there was negligence on the part of the petitioner or not was a matter of trial and would be decided after taking evidence during the course of the trial.

Issue of Consent

In **Arun Balakrishnan Iyer and Anr vs. Soni Hospital and Ors**[11] , the Madras High Court held that, the removal of the uterus without the consent of the petitioners did not give rise to an actionable claim; but, the defendants were bound to pay compensation for the negligence during the operation and the mental agony the petitioner went through because of the negligence. The plaintiffs were residents of Jaipur and the wife had been advised to undergo an operation for the removal of an ovarian cyst by the doctors at the Soni Hospital in Jaipur. The operation was performed after getting the consent of both the plaintiffs. During the operation the doctor informed the husband that the uterus would have to be removed. The uterus was removed, but she was informed about that only a month and a half later. However, the condition of the plaintiff continued to deteriorate with severe abdominal pain. The defendant after the initial treatment stated that the pain was not related to the operation and that she should see a general physician. The general physician could not make a diagnosis. Fed up with the treatment and also with the her medical condition the petitioners moved to Madras with their children.

In Madras the wife was admitted to the City Tower Nursing Home and was under the treatment of Dr. Vardharajan. An x-ray of the patient showed that there was an enlargement of the intestine with an abscess cavity surrounded by attachments of the intestine. Dr. Vardharajan advised immediate surgery that was performed on September 11, 1990. During the operation Dr. Vardharajan found an abdomen pad lying near the small intestine. There was a mark of 'Soni Hospital' on the pad. From the report and findings of Dr. Vardharajan it is clear that the defendants were negligent regarding the operation conducted on the wife and had closed the abdomen without adequately checking for foreign objects.

[10] Death caused by act with intent to cause miscarriage and without woman's consent
[11] AIR 2003 Mad 389

A special leave application was filed in the Madras High Court. The plaintiffs maintained that they had to suffer huge losses as the husband had to close down his business and move to Madras with the family, the plaintiffs were not consulted before the removal of the uterus and also the wife went through a lot of physical and mental agony due to the negligence of the doctors at the Soni Hospital.

The defendant doctors contended that the removing of the uterus was a necessity and the plaintiffs had given consent to that. Regarding the leaving of the abdominal pad in the stomach of the plaintiff, the defendants denied that and stated that a person would not have survived for 11 months if such a thing had happened.

After examining witnesses from both the sides and hearing the arguments the court came to conclusion that there was negligence on the part of the doctors in leaving the abdominal pad in the stomach of the plaintiff but held that the plaintiffs could not be compensated for the removal of the uterus. The plaintiffs had in all demanded compensation of Rs. 15 lakh, but the court awarded compensation of Rs. 3.35 lakh.

This is an important case where the courts recognized the negligence on the part of the doctors and awarded compensation to the plaintiffs. But considering the physical and mental agony the petitioner had to go through and the way the family was unsettled as they had to leave Jaipur and move to Madras the compensation was too little. The plaintiffs filed a suit before the court in Madras. Importantly the doctors had never informed the plaintiffs prior to the operation that there might be a possibility that the uterus would have to be removed—only the husband was informed while the operation was going on and the wife was under anesthesia. Yet, the court held that it was not negligence on the part of the doctors.

Status of Foetus

In **Ms.X vs. Mr. Z and Anr**[12], the Delhi High Court held that an aborted foetus was not a part of a body of women and allowed the DNA test of the aborted foetus at the instance of the husband though the application was opposed by the wife and she had stated that it would be the invasion of her privacy to carry out the DNA test on the aborted foetus. This case mainly arose out of a marital dispute. The wife had filed a case for the dissolution of the marriage on the grounds of cruelty and adultery. The husband also alleged that wife was involved in an adulterous affair. The husband also alleged that the wife was pregnant from her adulterous affair and the pregnancy was terminated at the All India Institute of Medical Sciences.

The husband maintained that he had come to know that records and slides of tubular gestation of the petitioner had been preserved in All India Institute of Medical Science. It contained cells of the aborted foetus and therefore, asserting that he was not the father of stated that a DNA test would also be beneficial and would establish as to who was the father of the aborted foetus. The wife through this petition before the high court contended that she could not be forced to undergo a DNA test as the foetus was part of her body and also it would be an invasion of her privacy.

The high court in its order agreed that nobody could be compelled to undergo a DNA test; but held that the foetus did not anymore remain a part of the body of the wife as it had been aborted. On the question of the right to privacy, the court came to the conclusion referring to various judgements of the Apex Court that, though the right to privacy had been recognized as a basic fundamental right but it was not an absolute right. The court held:

The position herein can again be taken note of. As already referred to above, the foetus is no more a part of the body of the petitioner. The petitioner indeed has a right of privacy but is being not an absolute right, therefore, when a foetus has been preserved in All India Institute of Medical Science, the petitioner, who has already discharged the same cannot claim that it affects her right of privacy. Adultery has been alleged to be one of the grounds of divorce. At this stage, the Court is not expressing any opinion on merits of the matter,

[12] 96 (2002) DLT 354

but the petitioner indeed cannot resist the request of respondent No. 1. However, if the petitioner was being compelled to subject herself to blood test or otherwise, she indeed could raise a defence that she cannot be compelled to be a witness against herself in a criminal case or compelled to give evidence against her own even in a civil case but the position herein is different. The petitioner is not being compelled to do any such act. Something that she herself has discharged, probably with her consent, is claimed to be subjected to DNA test. In that view of the matter, in the peculiar facts, it cannot be termed that the petitioner has any right of privacy.

The DNA test of the aborted foetus was allowed by the Delhi High Court.

Misuse of Medical Technology

In **Cehat and Ors. vs. Union of India**[13] a public interest litigation filed for the implementation of the Pre Natal Diagnostic Techniques and (prevention of misuse) (PNDT) Act. The act was amended during the course of this petition and the Apex Court passed various orders for the effective implementation of the Act. In this case, CEHAT, MASUM an NGO and Sabu George an individual activist filed a petition before the Supreme Court stating that the PNDT act was not being implemented properly resulting in the falling female child sex ration in the country. The Supreme Court came down heavily on the central government and also the state government for failure to implement the act. It stated in its order that the so called economically progressive states were also lagging behind in the female child sex ratio and had failed in the proper implementation of the Act.

The Act was amended while the petition was pending in the Supreme Court and several directions were passed by the Supreme Court for its proper implementation. Following are some of the important directions passed by the Apex Court while disposing of the petition:

a) For effective implementation of the Act, information should be published by way of advertisements as well as on electronic media. This process should be continued till there is awareness in public that there should not be any discrimination between male and female child.
b) Quarterly reports by the appropriate authority, which are submitted to the Supervisory Board should be consolidated and published annually for information of the public at large.
c) Appropriate authorities shall maintain the records of all the meetings of the Advisory Committees.
d) The National Monitoring and Inspection Committee constituted by the Central Government for conducting periodic inspection shall continue to function till the Act is effectively implemented. The reports of this Committee be placed before the Central Supervisory Board and State Supervisory Board for any further action.
e) As provided under Rule 17(3), public would have access to the records maintained by different bodies constituted under the Act.
f) Central Supervisory Board would ensure that the following States appoint the State Supervisory Board as per the requirement of Section 16A. 1. Delhi 2. Himachal Pradesh 3. Tamil Nadu 4. Tripura 5. Uttar Pradesh.
g) As per requirement of Section 17(3)(a), the Central Supervisory Board would ensure that the following States appoint the multi-member appropriate authorities:
   1. Jharkhand 2. Maharashtra 3. Tripura 4. Tamil Nadu 5. Uttar Pradesh
   It will be open to the parties to approach this Court in case of any difficulty in implementing the aforesaid directions.

Failure of Vasecotmy and Medical Negligence

In **Shakuntala Sharma vs. State of U.P,**[14] a husband's vasectomy operation failed. Before they knew of this failure, the wife got pregnant. The burden of the aspersions cast on her, and the onus that she felt shift onto her upon the arrival of the unexpected child, was the subject pf the case in

[13] AIR 2003 SC 3309
[14] 2000 Allahabad Law Journal 1550

the high court. The state was directed to pay her compensation

...for her mental agony and torture and insult and humiliation... as well as for expenses she had incurred in bringing up the child.

As she did not want another child,
it is the duty of the state to maintain the child...

Suppose she were to wish to contest local elections? Would the law, in one breath, acknowledge the error and demand an apology and reparation from the state, while disqualifying her from seeking a share in local political power? In **A.K. Reddy vs. Depot Manager, APSRTC**,[15] a driver was given an incentive increment when his wife went through a tubectomy after their second child. She died thereafter. He remarried and had a child with a second wife. He was declared disentitled to the incentive increment, not only in the thereafter, but he was also to repay what he had received thus far. Should such changed circumstances invite punishment?

Non- implementation of Guidelines on Standards of Female Sterlization

In **Ramakant Rai and Health Watch UP. and Bihar vs. Union of India**[16] petitioners contended that the respondents "have totally failed and neglected to implement" the Ministry of Health and Welfare's Guidelines on Standards of Female Sterilization (the Sterilization Guidelines), which were enacted in October 1999. The petititon invoked international source of law, emphasizing, "India ratifies many conventions that promote reproductive rights." With special focus on women, health services and discrimination against women[17] highlighting the salient features of the Alma Alta Declaration, CEDAW, the ICPD Programme of Action, and the Beijing Platform for Action, the petition framed its arguments based on the rights framework established through these international consensus documents. The petition relied upon domestic law, too, arguing that the respondents have "failed to realize" the constitutional right to health, which is a part of the right to life enshrined in Articles 14, 15, 21, and 47. In addition, the petition cited domestic case law in which the Supreme Court established the right to health, held the government vicariously liable for medical negligence, and recognized a right to compensation stemming from governmental negligence.

On March 1, 2005, an interim order that left the case open, enabling the Court to plan an ongoing monitoring role. The interim order noted that the affidavits filed by the respondent states "setting out the steps taken by them to regulate sterilization procedures" revealed that "there is no uniformity with regard to the procedures nor the norms followed for ensuring that the guidelines laid down by the Union of India in this regard are being followed." Drawing upon best practices from the state affidavits, the Court directed all states to take the following steps:

(1) Establish an approved panel of doctors to carry out sterilizations in accordance with uniform qualification criteria to be laid down by the central government;
(2) Prepare and circulate a checklist of patient data that every doctor must complete before conducting a sterilization procedure;
(3) circulate uniform copies of a patient consent form, based on the model used by the State of Uttar Pradesh;
(4) set up a quality assurance committee to issue biannual reports;
(5) maintain overall statistics about sterilization procedures and resulting deaths;
(6) Hold an inquiry and take punitive action in every case where the Sterilization Guidelines are breached; and
(7) Bring into effect an insurance policy, based on the model followed by the State of Tamil Nadu.[18]

The Court directed the central government to establish uniform standards on various issues—including norms for compensation, formatting of statistics, uniform checklists,

[15] 2000 Andhra Law Times 214
[16] Writ Petition (C) No 209 of 2003, pending in the supreme court
[17] Supra note 736, at para 11
[18] In October 2005 the court partly modified its order to double the compensation amount in states where insurance schemes were not viable due to the low rate of sterilization deaths

consent forms, and an insurance policy—within four weeks. In the interim, the Court instructed all states to follow the compensation norms of the State of Andhra Pradesh.

In response to the PIL, the central government has issued a National Family Planning Insurance Scheme to award monetary compensation to women and their families in cases of complications, pregnancy, or death after sterilization procedures in either government or accredited private health facilities.[19]

Clinical Research and Trials

'Indian women could not be used as guinea pigs..." stated Justice A.S. Anand, when he pronounced his judgement banning the use and sale of Quinacrine for female sterilisation, was only reiterating a basic article of human rights.[20]

While the controversy over Depo Provera, a long acting injectable hormonal contraceptive for women, was taking place world wide, in India, clinical trials of Net-en (Norethisterone Enanthate) were being conducted in violation of the Helsinki Charter on Clinical Trials. Net-en, the bi-monthy injectable introduced by the German pharmaceutical Schering AG, created waves. This drug worked by inhibiting the production of gonadotropin, a hormone secreted by the pituitary gland that prevents ovulation. The Indian Council of Medical Research (ICMR) began conducting trials on the drug in August 1984. The fact that the women who were undergoing these trials were not properly briefed about the possible side-effects of this drug, like heavy bleeding and hypertension, goaded the Stree Shakti Sanghatana of Hyderabad and Saheli to file a joint writ petition in the Supreme Court in 1986, demanding a halt to such trials.

In **Stree Shakti Sanghathana vs. Union of India** [21] women's activist battled in the court and took to the streets protesting the introduction into the population control programme of Net- en, manufactured by Schering AG, Germany marketed by German remedies and Depo provera manufactured by Upjohn co. USA and marketed by Max Pharma, India. Their argument was based on Article 21, or the right of a woman to a life with dignity: Net-en trials are being conducted without the informed consent of participants. They have violated the ICMR's own stated criteria of ethics and also transgressed the Helsinki Declaration on Human Experiment to which India is a signatory. After 14 years of a prolonged legal confrontation, the activists wrested from the government an undertaking that Depo-provera would not be allowed for 'mass use ' in the family planning programmeand that Net- En would be introduced "only where adequate facilities for follow up and counseling are available".[22]

Conclusion

In a case of **Samar Ghosh vs. Jaya Ghosh**,[23] the Supreme Court in a 71-page verdict has held that undergoing vasectomy or sterilisation operation by either of the spouses without the other's consent is a strong reason for the aggrieved partner to allege mental cruelty and seek divorce. Writing the judgment, Justice Bhandari said if a man underwent sterilisation without medical reasons and without the consent or knowledge of his wife and similarly if a woman underwent tubectomy or abortion without medical reason or without the consent or knowledge of her husband, such an act might lead to mental cruelty. The bench also held that "a unilateral" decision of refusing to have intercourse for "considerable period" without any "physical incapacity or valid reason" may also amount to mental cruelty .This case is a major blow to women's rights and in fact also goes against the MTP act which clearly states that consent of husband is not required if the women fulfils the conditions and wants to end her pregnancy.

It is clear through these judgements that there is no uniform policy regarding the harm caused to

[19] Manual for family planning insurance scheme 2 (2005)
[20] See chapter on drugs for the case.
[21] Writ Petition C No 680 Of 1996 decided on August 24, 2000.
[22] Last Affidavit of UOI on which basis the case was closed.
[23] www.manupatra.com (accessed on April, 20th 2007)

the victims due to failed sterilization surgeries or negligence during the pregnancy. In most cases the victims have been compensated monetarily but there are hardly any cases where the accused have been punished for their negligent act. Also importantly looking at the time frame in these cases, it shows that the victims have to go through a long and tedious method of civil suits and appeals where it takes more than 20 years for the appeals to be finally decided in the apex court.

There is a possibility that there are many unreported cases of negligence in the area of reproductive issues. The governments have not come up with any concrete policies regarding the reproductive rights of women in India. The Supreme Court and the various high courts have also missed an opportunity in terms of recognizing the rights of women to safe pregnancy, sterilization and abortion. The action and the orders in the individual cases do not help the issue, as each time a wrong has been committed it will be upto the women and her relatives to fight for justice which invariably many times is costly, lengthy and time consuming process.

Importantly though the Supreme Court has directed the governments to implement the PCPNDT Act properly, on the other hand it has upheld the two child norm policies of the government in some states, which can adversely affect the female child sex ratio. Thus the attitude of the judiciary towards the issue of reproductive rights in the last decade has been anti-women.

References:

1. ICPD (1994): ICPD Programme of Action, 1994, para 7.3
2. Buch, Nirmala [2005]: 'Law of Two Child Norm in Panchayats : Implecations, Consequences and Experiences', *Economic and Political Weekly*, June 11, pp2422
3. Rotimi AK, Eedarapalli P. Female Sterilisation URL:http://www.sexualhealthmatters.com/v2iss2/article4.html (accessed on April 18, 2007).
4. Chapron C, Querleu D, Bruhat MA, et al.(1998): 'Surgical Complications of Diagnostic and Operative Gynaecological Laparoscopy: A Series of 29,966 Cases'. *Hum Reprod* 1998;13:867-72.

Twelve

National Human Rights Commission

Adv. Kamayani Bali Mahabal

Introduction

There are different ways of protecting human rights. A pluralist and accountable parliament, an executive that is ultimately subject to the authority of elected representatives and an independent, impartial judiciary are all necessary, but not sufficient, institutional prerequisites [Burdekin and Anne Gallagher, 1998]. Besides these basic 'institutions' there are other mechanisms whose establishment and strengthening will enhance the existing mechanisms. In this chapter look at the National Human Rights Commission as an alternative way of protecting human rights. Although Andhra Pradesh, Assam, Himachal Pradesh, Jammu & Kashmir, Kerala, Madhya Pradesh, Maharashtra, Manipur, Orissa, Punjab, Rajasthan, Tamil Nadu, Uttar Pradesh, West Bengal, Chattisgarh and Gujarat all have their own state human rights commission each we could not focus on them due to non-availability of cases.

- What is the National Human Rights Commission (NHRC)?
- To what extent can NHRC help in making the government accountable?
- Is NHRC in India effective in protecting human rights?

NHRC can establish a culture of accountability as it is charged with monitoring the state's performance constantly. Without effective monitoring, states cannot be held accountable for non-implementation of, or be made liable for, violation of human rights. Of course, this monitoring work can be done to a certain extent through the judiciary but the NHRC has the potential to accomplish this task more effectively. It has to be proactive without being confrontational, so that public interest does not suffer because of unnecessary and unproductive competitiveness with other governmental bodies. It has to take the initiative rather than have a prescriptive view. NHRC India was the first National Human Rights institution to be established in South Asia. Its record has not been completely uncontroversial in its decade-long existence but it has taken tough and independent stands on several occasions. Despite its weak foundation, NHRC (India) is effective and demonstrates that human rights protection does not have to rely entirely on the courts. Gradually it has become locus of human rights awareness at the national level.

(i) Mandate

NHRC India has limited mandatory powers. The Human Rights Protection Act, 1993 takes a very narrow view of human rights and provides that 'human rights' means the right relating to life, liberty, equality and dignity of the individual guaranteed by the Constitution of India or embodied in the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (ICESCR) and enforceable by the courts in India. So, the main drawback of this statutory definition seems to be that it curtails the mandate of the commission by limiting it to the rights enshrined in the two covenants and the Constitution. As India subscribes to the dualist pattern with regard to the relationship between international treaty law and domestic law, theoretically speaking the commission cannot discharge its responsibility for protecting rights in the covenants unless the Parliament enacts domestic legislation incorporating these rights. While the Supreme

Court has reiterated this dualist approach to enforcement of international treaty law in India,[1] lately it has dealt with this issue differently. [2]Besides this India has signed several other International treaties but due to this limited definition NHRC's mandate is restricted to the two covenants alone. But this factor does not diminish the magnitude of its task or its potential to protect India's citizens and to develop a culture respectful of human rights and fundamental freedoms.

(ii) Composition

The Human Rights Act, 1993 sets out the legal framework of the NHRC. The composition of NHRC is high-powered as three out of its five members are judges. The chairpersons of the National Commission for Minorities, the National Commission for the Scheduled Castes and Scheduled Tribes (SCST) and the National Commission for Women are all deemed (ex-officio) members of the commission. The remaining two members must be men and women "who have knowledge and practical experience in matters relating to human rights".

(iii) Powers

By holding the government accountable for existing or past violations of human rights, the NHRC can play a vital role in fulfilment of national and international human rights norms. It accepts complaints regarding human rights violations and asks for explanations from the government. If it is not satisfied with the reply, it starts an independent investigation, in the course of which, the commission among other things can summon and force witnesses to appear before it and then examine them under oath. It can also call for relevant documents. In its proceedings; the NHRC is endowed with all the powers of a civil court.[3] Sometimes the NHRC initiates a general public inquiry also. Following investigation, the NHRC can award compensation or can issue directions. It has been successful sometimes, in persuading the state to pay compensation to victims of human rights violation. It can also recommend the granting of 'immediate interim relief' to a victim of human rights abuse or to his or her relative.

(iv) Suo Moto Powers

The commission can receive complaints or investigate on its own about 'violation of human rights or abetment thereof or negligence in the prevention of human rights violations by public servants'.[4] These powers to initiate suo moto inquiries are an important aspect of its protective functions that can be fully utilised. This is particularly relevant in those situations, which involve individuals or groups belonging to the marginalised sections of society who do not have the financial or social resources to lodge individual complaints. It is these vulnerable groups, which are the ones most likely to be unaware of their rights and of the mechanisms, which protect these rights. The Commission has taken cognisance of many news reports here and those by foreign news agencies.

NHRC has adopted a proactive approach in the area of Economic, social and cultural rights. The commission has taken the issue of starvation deaths in the state of Orissa very seriously. With the help of its Special Rapporteur,[5] the commission has been monitoring the situation on a continuing basis. In this matter it has taken the view that the Right to Food is inherent to a life with dignity, and Article 21 of the Constitution of India which

---

[1] Jolly George vs. Bank of Cochin, AIR 1980 SC 470(where the Supreme Court held that rights contained in an international treaty that India has signed do not become a part of the corpus juris of India until parliament makes implementing legislation incorporating those rights as quoted in Sripati Vijayshri, 'India's National Human Rights Commission: Strengths and Weaknesses', in Lindsnaes Birgit, Lindholt Lone & Yigen Kristine (edit.),*'National Human Rights Institutions-Articles and Working Papers'*, The Danish Centre for Human Rights, 2001,p.157

[2] See Vishakha vs. State of Rajasthan, AIR 1997 SC 323;(1997) 6 SCC 241, where while laying down guidelines for dealing with the problem of sexual harassment of women at the work place, the supreme court emphasised that international conventions and norms were to be read into the enforceable fundamental rights in the absence of domestic law occupying the field when there is no inconsistency between them.

[3] NHRC's Annual Report, 1996-1997

[4] The Protection of Human Rights Act, 1993,12(a)

[5] Special Rapporteur is a title given to individuals working on behalf of the United Nations who bear a specific mandate from the former UN Commission on Human Rights to investigate, monitor and recommend solutions to human rights problems

guarantees the fundamental right to life and personal liberty should be read with Articles 39(a)[6] and 47[7] to understand the nature of the obligations of the State in order to ensure the effective realisation of this right. The other important issues that NHRC has been concerned with are issues relating to HIV/AIDS and human rights. These include: consent and testing, confidentiality, discrimination in health care, discrimination in employment, women in vulnerable environments, children and young people, people living with or affected by HIV/AIDS and marginalised populations. After taking suo motu cognizance of the calamity arising from the devastating earthquake, which hit large areas in the state of Gujarat in 2001, NHRC constantly monitored the relief and rehabilitation measures undertaken by the government in the earthquake hit areas. The commission drew the attention of the government to the fact that the official machinery involved in rehabilitation should be able to take all the steps necessary for the equitable distribution of both relief as well as rehabilitation measures and that in the process, the poor, destitute women and children and old persons, who would be in greater need of relief and rehabilitation assistance, should not be deprived or made to suffer.

NHRC also follows up of public-spirited judgments of the Supreme Court of India. Indeed, in important instances, the Supreme Court has itself remitted to the commission matters that were before it. Notable among them are the cases relating to the allegation of starvation death in Orissa, the monitoring of programmes to end bonded and child labour, the mass cremation of unidentified people of Punjab and the proper management of institutions for the mentally challenged and protective home for women. A symbiotic relationship exists between the NHRC and the Supreme Court and the latter emphasised that the commission can bring sustained scrutiny on these matters.

NHRC is mandated under Section 12 of the Protection of Human Rights Act, 1993 to visit government- run mental hospitals and study the living conditions of the inmates and make recommendations thereon. The most notable intervention of the NHRC in mental health has been a project on Quality Assurance in Mental Health launched in 1997 to analyse the conditions generally prevailing in government- run mental hospitals in various parts of the country with reference to infrastructure, patient care, admission, discharge and appeal procedure, rehabilitation facilities, client satisfaction and morale of the staff. The project report 'Quality Assurance in Mental Health', with comprehensive recommendations was circulated by the commission to the health secretaries of all the States and UTs.

Important Judgements

Prisoners' Cases

1. The most infamous case is that of Ajoy Ghose who spent 37 years in jail till November 1999. Arrested for killing his brother in 1962, he was subsequently certified as insane. While he was in prison, the trial judge and all the witnesses died. His mother too expired after which he passed through serious emotional upheaval. And since he was legally declared a lunatic, he was not tried. It was under the initiative of the then Chief Justice of India and now NHRC chairman, Justice A.S. Anand, that he was shifted from Kolkata's Presidency Jail to a Missionaries of Charity home

The Punjab and Haryana High Court has accepted in toto NHRC's recommendations for mentally challenged prisoners languishing in the jails of the two states. The decision came in November 2006, while hearing the case of one Jai Singh, a mentally challenged person, who had died in prison after spending almost 30 years there as an undertrial (NHRC Annual Report, 2003-04).

In September 2004, NHRC had filed intervention application for impleading it as a party, in the Punjab and Haryana High Court to assist in the

---

[6] Article 39(a) of the Constitution, enunciated as one of the Directive Principles, fundamental in the governance of the country, requires the State to direct its policies towards securing that all its citizens have the right to an adequate means of livelihood

[7] Article 47 spells out the duty of the State to raise the level of nutrition and standard of living of its people as a primary responsibility

pending civil writ petition in the case of mentally ill under trials in jails. It took this decision while pursuing the case of Jai Singh, who had been in custody as an under trial prisoner in the Ambala Central Jail for nearly 27 years. This case came to the notice of the commission when the chairperson Justice A.S.Anand visited the jail in October-2003. Soon the commission sought reports from the superintendent, Mental Hospital Amritsar, Superintendent, Central Jail Ambala, DIG Ambala Range and Addl. Sessions Judge Kurukshetra.

Jai Singh, who was sent to Ambala jail in September 1976 on murder charges, was later transferred to the mental hospital in Amritsar in May 1979 for treatment, and thereafter never produced in the trial court. A careful perusal of the various reports received by the commission projected a rather distressing picture. Jai Singh's case file had been consigned to the record room with the direction that the case would be summoned as and when the accused was fit to face trial. Medical reports appeared to have been sent to the court only intermittently. It appeared that Jai Singh had been reduced to a number and forgotten.[8]

In November 2004 NHRC received a representation from Jai Singh's wife as well, stating that she had been denied meetings with her husband. She prayed for his release on humanitarian grounds. While the case was still pending before the Punjab and Haryana High Court because of Jai Singh's incapacity to face trial, the court was informed that the prisoner had died in jail in October 2005.

2. The commission intervened in another case of one Charanjeet Singh, [9] a mentally ill inmate of Tihar Jail, Delhi in March 2005. In this matter also the commission presented before the Delhi High Court guidelines to be followed in the case of mentally ill prisoners. The Delhi HC directed the government of NCT, Delhi to adopt the guidelines suggested and to chalk out a proper strategy to deal with such cases of mentally ill prisoners who are convicts or undertrials. Following NHRC's impleading in the Jai Singh's case, the court also took note of 11 other mentally challenged persons. The court has asked the administration of the two states and the lower judiciary to follow the recommendations of the commission in **toto**.

i) Psychological or psychiatric counselling should be provided to prisoners as required in order to prevent mental illness and/or to ensure early detection. Collaborations of this purpose should be made with local psychiatric and medical institutions as well as with NGOs.

ii) Central and District jails should have facilities for preliminary treatment of mental disorders. Sub-jails should take inmates with mental illness to visiting psychiatric facilities. All jails should be normally affiliated to a mental hospital.

iii) Every central and district prison should have the services of a qualified psychiatrist who should be assisted by a psychologist and a psychiatric social worker.

iv) Not a single mentally ill person who is not accused with committing a crime should be kept in or sent to prison. Such people should be taken for observation to the nearest psychiatric centre, or if that is not available to the Primary Health Centre.

v) If an undertrial or a convict undergoing sentence becomes mentally ill while in prison, the State has an affirmative responsibility to the undertrial or convict. The State must provide adequate medical support. As such appropriate facilities should be provided in State assisted hospitals for undertrials who become mentally ill in prison. The person should be placed under the observation of a psychiatrist who will diagnose, treat and manage the person. In case such places are not available, the State must pay for the same medical care in a private hospital. In either case care must be provided until recovery of the undertrial/convict.

vi) When a convict has been admitted to a hospital for psychiatric care, upon completion of the period of his prison sentence, his status in all records of the prison and hospital should be recorded as that of a free person and he should continue to receive treatment as a free person.

[8] Writ Petition (C) 10791/2002
[9] Writ Petition (Cr) 729/2002 and 1278/2004, decided on: 04.03.2005

vii) Mentally ill undertrials should be sent to the nearest prison having the services of a psychiatrist and attached to a hospital, they should be hospitalized as necessary. Each such undertrial should be attended to by a psychiatrist who will send a periodic report to the Judge/Magistrate through the Superintendent of the prison regarding the condition of the individual and his fitness to stand trial. When the undertrial recovers from mental illness, the psychiatrist shall certify him as 'fit to stand trial'.

viii) All those in a jail, with mental illness and under observation of a psychiatrist should be kept in one barrack.

ix) If a mentally ill person, after standing trial following recovery from the mental illness is declared guilty of the crime, he should undergo term in the prison. Such prisoners, after recovery should not be kept in the prison hospital but should remain in the association barracks with the normal inmates. The prison psychiatrist will, however, continue to periodically examine him for reviewing his treatment and suggesting him other activities.

x) The State has a responsibility for the mental and physical health of those it imprisons.

3. Babu Lal, an undertrial prisoner who was admitted in the District Jail, Banda with burn injuries was sent to the District Hospital, Banda under police escort. He died while undergoing treatment in the hospital on November 22, 2000. The Commission observed that the records showed that instead of taking prompt action to follow the advice of the surgeon of the District Hospital, Banda, the jail authorities entered into a bureaucratic tussle with the police authorities on the point as to who was responsible for providing guard (escort) and transport for taking the victim prisoner to Lucknow Medical College for treatment.[10] The commission while looking into his case found a disturbing fact- that despite repeated recommendations of the doctor first made, as early as November 8, 2000, the patient was not shifted to the Medical College, Lucknow for specialized treatment. The authorities concerned kept exchanging correspondence for sorting out the issue of who would provide escort for shifting the patient from Banda to Lucknow. Because of this approach adopted by the authorities the patient could not be given proper medical treatment. The commission expressed its anguish at the utter lack of sensitivity on the part of the prison authorities in handling Babu Lal's case. The commission viewed it as a classic case of systemic failure resulting in a loss of life, which possibly could have been saved. It has stated that technical considerations for shifting a patient to the hospital cannot outweigh the right of the patient to proper health care and as such, his right to life.

The commission emphasised that Right to Life was a basic human right guaranteed as fundamental right under the Constitution of India. Therefore, it is the obligation of every state functionary to protect the life of a detenue in his custody and ensure proper medical treatment for him or her as and when required. It also recommended that appropriate directions be issued to all concerned that whenever a human life is involved and the case is of urgent nature, prompt action for proper medical treatment of the detainees should be taken by the officials concerned.

Medical Negligence Cases

1.Janadhikar, an NGO[11] approached the commission with a news report stating that Smt. Bihalavati, wife of Ram Prakash was taken to the District Hospital, Siddharth Nagar for delivery and though she was experiencing acute labour pain, she was not admitted by the staff nurse as her husband had failed to pay Rs.250/- as demanded by the latter. She was admitted only after other persons paid the amount. At around 1 p.m. when her condition became very serious, a General Duty Medical Officer examined her and referred her to Gorakhpur but before she could be taken to Gorakhpur, she expired. It had been alleged that Smt. Bihalavati died due to negligence and carelessness on the part of doctors of the District Hospital, Siddharth Nagar as her husband had

[10] Technicalities cannot outweigh right of undertrial prisoners. Patent to health care : NHRC, 16th Dec 2005 available at http://www.nhrc.nic.in/disparchive.asp?fno=1117 (accessed on April, 10th 2007)

[11] http://nhrc.nic.in/dispArchive.asp?fno=1035 (accessed on April, 10th 2007)

failed to meet their illegal demand. The commission directed the Uttar Pradesh government to pay a sum of Rs.50, 000/- by way of interim relief to the next of kin of Smt. Bihalavati who died on 12 August 1999 due to negligence and carelessness on the part of doctors of the District Hospital, Siddharth Nagar, Uttar Pradesh. The compensation was given by the state government.

2. Smt. Ram Kumari in her complaint[12] to the commission stated that her late husband, Shri Krishan Kumar, died in a road accident when his truck collided with a tree and caught fire thereafter. The police prepared an inquest report and sent the burnt body of her husband for post-mortem to Rai Bareilly. A team of three doctors performed the autopsy on 17 May 1998 but were unable to give an opinion on the cause and time of death and, therefore, sought the opinion of the state medico-legal expert. The opinion was delayed by six months, as a result of which the complainant was made to rush from Allahabad to Rai Bareilly to plead with the authorities to hand over the remains of her husband's dead body for performing the last rites. The complainant sought the commission's assistance in getting the dead body released early.

From the reports, the commission noted that the bodily remains of the deceased were handed over to the complainant nine months after the death; this had resulted in mental agony to her and forced her to rush to Rai Bareilly to contact the authorities. It held that this avoidable delay was directly attributable to the gross negligence of the state authorities at different levels. In the circumstances, the commission recommended the payment of interim compensation of Rs.10, 000 to the complainant by the government of Uttar Pradesh within two months that has since been paid.

3. The Maharashtra State Human Rights Commission received a complaint regarding the death of one. Mala Bharat Jadhav,[13] during a sterilisation operation. The commission took cognisance, as a result of which, on the finding recorded by quality assurance committee headed by Dr. K. S. Bhise, Deputy Director of Health Services, Akola, the husband of the deceased was recommended compensation of Rs. 40,000, even though it was not a case of medical negligence.

4. In a compliant by chairman Social Welfare Council , Nayagarh, Orissa informed the Commission that one Mr Sethi was bitten by a stray dog and he went to the District Hospital Nayagah for free shots of the vaccine But in the hospital rabies vaccine was not preserved in cold storage . He received anti rabies injections on his stomach for seven days, but because of an adverse raection to the vaccine, he develoeped partial paralysis and malfunctioning of a kidney. He had no means to undergo treatment in a private hospital and was fighting for his life. The complainant prayed for an independent inquiry into the negligence of the medical personell of the hospital and adequate compensation for maintenance and treatment of the patient. The commission conducted inquiry and directed departmet of family and health to pay a compensation of Rs. 2 lakh for further treatment.[14]

5. In a case of medical negligence, which came to MSHRC. The complainant, Siva Salian,[15] advocate was not allowed to see his wife who was admitted in KEM Hospital on January 1, 2001 due for a breathing problem. Three days after her admission her condition was reported to be critical. She died on January 23 at 6:20 a.m. The complainant made two allegations. Firstly, the doctor-in-charge refused to allow the complainant and his younger daughter Dr. Supriya to see the patient even when she was in a critical condition, and second though the patient desired to see her husband and daughters while she was in the ICU, they were not allowed to do so. They alleged that there had been violation of the human rights. The commission took into account the importance of the doctor- patient relationship and his/her family member or relatives. It was observed that advances in medical sciences and dramatic changes in health care coverage had altered the physician-patient relationship and the treatment option available to health care professionals. The doctor -patient relationship is founded on trust but health care has

[12] Case No.7122/24/98-99
[13] Case No. 2002/2002 : Order dt. 4/4/03
[14] Case No 359/18/99-2000
[15] Case No. 109/01: Order dt.19/05/04

become less personal or more corporate as a result doctors often ignore the rights of patients or families and relatives. Consequently, this prevents the doctor and others from respecting and carrying out the patient is dying wish.

The commission further observed that although it is true that primary obligation of medical personnel was to the patient yet when the patient is dying the needs of his/her family take precedence. To ignore the rights of the bereaved family can lead to violation of value and dignity. The commission cited research literature in this regard and pointed out that human beings possess an inherent value that is independent of the state of their health or their closeness to death. If human beings have freedom of choice and action, then, for a humanistic perspective, both the patients and relative should share their views. The relationship between the doctor and dying patients includes "the moment of truth". This is not always identical to the time of explanation. Therefore, during the final crisis when it is no longer possible to stave off death, the patient has the greatest need of conversation not only with the doctor but also with her relatives. The commission, therefore, stated that such factors considerably increased the urgency on attitudes and how the doctor should have behaved at the moment. The ground rule, therefore, is that in any case the patient's relative should have been permitted to see the patient even though she was in Inermediate Respiratory Care Unit (IRCU). In conclusion, the commission stated that patient's rights are a reflection of human rights; they are recognised throughout the world, when declaration on the promotion of patient's rights 1994 was entered into at the behest of World Health Organisation. Until recently, the health professional- patient's relationship was primarily defined by the rules of medical ethics but now the focus had shifted to legal provisions and the issue started gathering larger international attention. In this context, the commission relied on Article 21 of the Constitution of India, which guarantees the most important right– the right to life. The term "Life" means something more than mere animal existence. The prohibition against its deprivation extends to all those limbs and faculties by which life is enjoyed. Right to life and human dignity means mixing and co-mingling with fellow human beings. Any act, which offends or impairs human dignity, would constitute deprivation protanto of this right of life unless it is done by reasonable and just procedure established by law, which stands the test of other fundamental rights. In substance, respect of human rights and values in health care becomes an important issue, which confirms the basic principal in our constitutional law, the inalienable nature of human dignity. Arrogance, nepotism, therefore, become unknown to man's status.

After considering the code of medical ethics prescribed by the Maharashtra Medical Council as well as Medical Council of India, the commission recommended the practice to protect the rights of patient, his/her relatives or family members or friends as more particularly mentions in the directions. In response to the recommendation of the Commission, the Municipal Commission Brihanmumbai Municipal Corporation, Mumbai implemented the directions by means of circular to all hospitals under his control by prescribing timing visit of patient's relatives in IRCU/ICU. The commission, also recommended to the government to apply similar procedure and the government has with certain modification issued the guidelines to all hospitals under their control to follow up.

Occupational Health

The commission took suo motu cognisance of a news item in the *Sunday Observer* in September 1996 captioned 'Death in the Air' and called for a report from the government of Madhya Pradesh. The report indicated that there were 134 slate factories which were set up in Mandsaur District of Madhya Pradesh. A majority of the workers employed in these factories had been affected by the inhalation of silicon dust. The government had taken steps to provide medical facilities and ensure that all these workers were covered under the Employees State Insurance (ESI) scheme. There was a mobile van in operation to provide medical facilities to the workers. They were even provided with pensions on the declaration that the disease affected the worker, which was an occupational hazard. The district administration had advised owners of these factories to install BHEL machinery to minimise dust particles. However,

many of the owners of these factories were unable to meet the cost of the sophisticated machinery. This resulted in the spread of silicosis dust and affected the workers' health. The labour inspectors had visited the factories and prosecuted those who were not applying the minimum standards laid down. Having regard to the provisions of the Indian Constitution as well as to the International Human Rights instruments with regard to the right to life the commission gave the following directions to the state for compliance in future:-

1. To ensure the establishing of BHEL machinery in the factories to prevent dust pollution and to ensure that pollution free air is provided to workers.
2. Periodic inspection, on a monthly basis, by the Labour Department and reports made to the State Human Rights Commission for monitoring.
3. Widows and children of deceased workers to be taken care of by the factory owner by providing assistance.
4. To ensure that child labour is prevented by the following methods:
   (a) Establishing schools at the cost of factory owners, with assistance from the State for the education of workers' children.
   (b) The provision of periodic payments for their education and insurance coverage at the cost of factory owners.
   (c) The position of mid-day meals and clothing to dependent children or children of deceased workers.

In examining this matter, the commission observed that the Right to Health and Medical Care was a fundamental right under Article 21, read with Articles 39(e), 41 and 43 of the Constitution. The Right to Life includes protection of the health and strength of workers and was a minimum requirement to enable a person to live with human dignity. The Universal Declaration of Human Rights as well as other International Instruments also spoke of this right. Continuous exposure to the corroding effect of silicon dust could result in the silent killing of those who worked in such an environment. The duty of the state, under the Directive Principles of the Constitution, was to ensure the protection of the health of workers employed in such slate factories in Mandsaur and elsewhere in the state.

Starvation Deaths

On December 3, 1996, the commission took cognisance of a letter from Chaturanan Mishra, then Union Minister for Agriculture regarding starvation deaths due to the drought in Bolangir district of Orissa. In a similar matter a writ petition[16] was filed by the Indian Council of Legal Aid and Advice and others before the Supreme Court of India under Article 32 of the Constitution. The petition alleged that deaths by starvation continued to occur in certain districts of Orissa. The Supreme Court on 26th July 1997 directed that since the NHRC is seized of the matter and is expected to deliver some order, the petitioner can approach the commission. Realising the urgency of the matter the commission acted quickly and initially prepared an interim measure for the two-year period and also requested the Orissa state government to constitute a committee to examine all aspects of the land reform question in the KBK Districts.[17] A Special Rapporteur[18] has been regularly monitoring the progress of implementation of its directions. The commission observed that starvation deaths reported from some pockets of the country are invariably the consequence of mis-governance resulting from acts of omission and commission on the part of the public servant. The commission strongly supported the view that to be free from hunger is a Fundamental Right. Starvation, hence, constitutes a gross denial and violation of this right.[19]

The commission organised a meeting with leading experts on the subject, in January, 2004 to discuss issues relating to Right to Food.[20] It has approved

---

[16] Writ Petition (C) No.42\97.
[17] http://nhrc.nic.in/HRIssue.htm#Right%20to%20Food (accessed on April, 3rd 2007)
[18] ibid
[19] ibid
[20] ibid

the constitution of a Core Group on Right to Food that can advise on issues referred to it and also suggest appropriate programmes, which can be undertaken by the commission.[21] By this decision, it is firmly established in the context of India that economic, social and cultural rights are treated at par with the civil and political rights before the courts and the commission. India is amongst the few countries in the world, which have accorded justiciability of economic, social and cultural rights.

The issue of starvation deaths was raised in Indian Council Legal aid case [21] by the Indian Council of Legal Aid and Advice and Others. On learning that the Commission had taken cognisance of this matter, the Supreme Court made the following observation in its Order dated July 26, 1997:

In view of the fact that the National Human Rights Commission is seized of the matter and is expected to give its report after an enquiry made at the spot, it would be appropriate to await the report. Learned Counsel for the petitioner submitted that some interim directions are required to be given in the meantime. If that be so, the petitioner is permitted to approach the National Human Rights Commission with its suggestion. So far as this Court is concerned, the matter would be considered even for this purpose on receiving the report of the National Human Rights Commission. We also consider it appropriate to require the Union of India to appear before the National Human Rights Commission to assist the Commission in such manner as the Commission may require for the purpose of completion of the task of the Commission. The learned Addl. Solicitor General undertakes to ensure prompt steps being taken for this purpose.

After a decade long study which was completed in 2006, the NHRC report confirmed that t at least 17 of the 21 starvation deaths reported in 1996-97 in Orissa were due to chronic hunger and malnutrition. All the deaths were in Kalahandi, Bolangir and Koraput or the severely deprived KBK region of Orissa. The report attributes the deaths to prolonged malnutrition and hunger compounded by extensive crop damage, poor income and inadequate relief measures. The commission has approved the constitution of a core group on Right to Food that can advise on issues referred to it and also suggest appropriate programmes, which can be undertaken by the commission.

Mental Health

Justice J.S. Verma, ex-chairperson, National Human Rights Commission, asked all the chief ministers of all the states and the administrators of all the union territories "to issue clear directions to the Inspector Generals of Prisons to ensure that mentally ill persons are not kept in jail under any circumstances". Moreover, the state government must make proper arrangements for their treatment in approved mental institutions and not treat them as unwanted human beings.[22] The commission has directed all States and union territories to certify that no mentally ill patient is kept in chains in any mental hospital/institution. A letter from the commission in this regard was sent to the chief secretaries/ administrators of all sates/UTs. The commission also directed all the states and UTS not to chain the mentally ill persons. The issue came up earlier on the basis of a complaint from Prof. Dr. Nazneen of Shri Meenakshi Government College for Women, Madurai regarding the plight of mentally ill patients staying in Sultan Alayudeen Durgah, Goripalayam, Madurai (Tamil Nadu). Taking cognisance of the matter, the commission had constituted a committee to visit the Durgah and make specific recommendations in regard to the proper care and treatment of the patients. The report submitted by the committee was accepted by the commission on 3 January 2001.

The commission took suo-motu cognisance of a media report, which showed gory details of inhuman treatment meted out to inmates of an unlicensed mental asylum run by a quack at Saharsa in Bihar. Reacting to the CNN-IBN news report, the commission said that the treatment methods shown in the report are primitive as the patients are tied to the tree and buckets of cold

[21] Writ Petition (C) No. 42/97 filed before the Supreme Court of India on 23 December 1996
[22] Vide letter dated March 3,2000

water are poured on them. The video clipping also showed mental patients being kept in chains and being brutally beaten up. The commission said the contents of the story, if true, were an affront to human dignity and raise an issue of violation of human rights of mental patients. It directed the chief secretary; Bihar to get the matter enquired into and submit a factual report within two weeks. It further directed that if the contents of the story were found to be true, the chief secretary should intimate the commission regarding the steps being taken for release of the mental patients and the steps taken to ensure that they are provided proper medical and psychiatric treatment.[23]

The National Human Rights Commission has taken suo-motu cognisance based on media reports of a government psychiatrist at the Agra Mental Asylum, Uttar Pradesh, having charged Rs. 10,000/- to certify women clinically insane so to enable their husbands to file for divorce. A report has been sought within two weeks from the director of the hospital and the home secretary, department of home, Uttar Pradesh. As per the media report, the psychiatrist Dr. S. K. Gupta had facilitated 10 such divorces by issuing false certificates. It was also reported that Dr. Gupta has "disappeared".[24]

The managements of the mental hospitals at Ranchi, Agra and Gwalior came under the scrutiny of the Hon'ble Supreme Court through Writ Petitions (C) No.339/96, No.901/93, No.80/94 and No.448/94 filed by social activists. The Supreme Court in its order dated 11th November1997 requested the National Human Rights Commission to be involved in the supervision of the functioning of these three hospitals. In pursuance of the Order, the commission has been monitoring the functioning of these hospitals through its Special Rapporteur. It had constituted an expert group on 31st December 2001 for rehabilitation of long stay patients who are languishing in these three mental hospitals even after having been cured of mental illness.

Although commission has done a lot in the area of mental health, there is a blot which lingers on the commission for discriminating people on the basis of their sexual orientation. A petition was filed in the case of a patient from the All India Institute for Medical Sciences (AIIMS), who was being treated by a doctor at the AIIMS psychiatry department for the past four years to cure him of his homosexuality. The patient himself noted that,*"Men, who are confused about their sexuality, need to be given the opportunity to go back to heterosexuality. I have never been confused but was nevertheless told that I had to be 'cured' of my homosexuality. The doctor put me on drugs which I had been taking for four year ."*

The patient went to the Naz Foundation India (an organization working on Men who have Sex with Men (MSM) issues), and the coordinator of the MSM Project, Shaleen Rakesh, filed a complaint with the National Human Rights Commission (NHRC), alleging psychiatric abuse involving a patient at the All India Institute of Medical Sciences (AIIMS). The treatment reportedly involved two components: counselling therapy and drugs.

The NHRC, admitted the complaint (No. 3920, filed on May 29, 2001), but finally chose to reject it. In its formal dismissal of the complaint, it did not offer any written or oral opinion on the issue, and merely rejected the complaint that requested the NHRC to address the psychiatric treatment of homosexuality from a human rights perspective.[25] Informal conversations with the chairperson of the NHRC revealed some of the reasons why the NHRC chose not to address the issue. The chairperson believed that till Section 377 (xiv) Indian Penal Code was changed, nothing could be done. Also, most of these organisations were funded by international bodies and there was no real grass roots support. According to another NHRC source, "Homosexuality is an offence under IPC, isn't it? So, do you want us to take cognisance of something that is an offence?"[26]

---

[23] NHRC Order June 20, 2006.
[24] NHRC Order July 5, 2004.
[25] 'Medicalisation of Homosexuality – a human rights approach ', Combat law Vol 1 Issue 1, March - April 2002.
[26] The Pioneer, Thursday, August 2, 2001.

Right to Health Care

In November 2003, the commission approved a proposal received from the Jan Swasthya Abhiyan[27] (Peoples' Health Movement-a network of 1000 NGOs working in the health sector) to hold public hearings on Right to Health Care in five regions of the country followed by one at the national level in New Delhi. Subsequently, the western region hearing was held at Bhopal, Chennai, Lucknow, Ranchi and Guwahati. During these public hearings, selected cases or instances, wherein individuals or groups who have suffered denial of right to health care and have not received mandated health care from a public and private health facilities were presented. The commission brought victims, NGOs and concerned authorities on the same platform, which helped in the resolution of individual problems, identification of systemic problems and forging of partnerships. Over 1000 victims from marginalised sections presented their testimonies. The Commission and the concerned authorities are redressing their complaints. Systemic improvements in health care have been suggested to all concerned authorities. The active participation of NGOs and state governments has contributed considerably to the success of this programme.[28]

The National Public Hearing was held in New Delhi on December 16-17, 2004, in which civil society representatives presented the structural deficiencies noted in various regional public hearings, followed by delineation of state-wise systemic and policy issues related to denial of health care. Special presentations were made on issues such as women's right to healthcare, children's right to healthcare, mental health rights, right to essential drugs, health rights in the context of the private medical sector, health rights in situations of conflict and displacement, health rights in the context of the HIV/AIDS, and occupational and environmental human rights. In addition, the National Action Plan to operationalise the 'Right to Health Care' was proposed.

NHRC Recommendations for a National Action Plan to Operationalise the Right to Health Care

Recommendations to Government of India / Union Health Ministry

Enactment of a National Public Health Services Act, recognising and delineating the health rights of citizens, duties of the public health system, public health obligations of private health care providers and specifying broad legal and organisational mechanisms to operationalise these rights. This act would make mandatory many of the recommendations laid down, and would make more justiciable the denial of health care arising from systemic failures, as have been witnessed during the recent hearings.

This act would also include special sections to recognise and legally protect the health rights of various sections of the population, which have special health needs: Women, children, persons affected by HIV-AIDS, persons with mental health problems, persons with disability, persons in conflict situations, persons facing displacement, workers in various hazardous occupations including unorganized and migrant workers, etc.

Delineation of model lists of essential health services at various levels: village/community, sub-centre, PHC, CHC, Sub-divisional and District hospital to be made available as a right to all citizens.

Substantial increase in Central Budgetary provisions for Public health, to be increased to 2-3% of the GDP by 2009 as per the Common Minimum Programme.

Convening one or more meetings of the Central Council on Health to evolve a consensus among various state governments towards operationalising the Right to Health Care across the country.

---

[27] For more details on JSA and the Right to Health Care campaign go to www.phm-india.org.
[28] Annual Report NHRC 2004-2005

Enacting a National Clinical Establishments Regulation Act to ensure citizen's health rights Concerning the Private medical sector including right to emergency services, ensuring minimum standards, adherence to Standard treatment protocols and ceilings on prices of essential health services. Issuing a Health Services Price Control Order parallel to the Drug Price Control Order. Formulation of a Charter of Patients Rights.

Setting up of a Health Services Regulatory Authority analogous to the Telecom regulatory authority, which broadly defines and sanctions what constitutes rational and ethical practice, and sets and monitors quality standards and prices of services. This is distinct and superior compared to the Indian Medical Council in that it is not representative of professional doctors alone – but includes representatives of legal health care providers, public health expertise, legal expertise, representatives of consumer, health and human rights groups and elected public representatives. Also this could independently monitor and intervene in an effective manner.

Issuing National Operational Guidelines on Essential Drugs specifying the right of all citizens to be able to access good quality essential drugs at all levels in the public health system; promotion of generic drugs in preference to brand names; inclusion of all essential drugs under Drug Price Control Order; elimination of irrational formulations and combinations. Government of India should take steps to publish a National Drug Formulary based on the morbidity pattern of the Indian people and also on the essential drug list.

Measures to integrate national health programmes with the primary health care system with decentralized planning, decision-making and implementation. Focus to be shifted from bio-medical and individual based measures to social, ecological and community based measures. Such measures would include compulsory health impact assessment for all development projects; decentralized and effective surveillance and compulsory notification of prevalent diseases by all health care providers, including private practitioners.

Reversal of all coercive population control measures, that are violative of basic human rights, have been shown to be less effective in stabilising population, and draw away significant resources and energies of the health system from public health priorities. In keeping with the spirit of the NPP 2000, steps need to be taken to eliminate and prevent all forms of coercive population control measures and the two-child norm, which targets the most vulnerable sections of society.

Active participation by Union Health Ministry in a national mechanism for health services monitoring, consisting of a Central Health Services Monitoring and Consultative Committee to periodically review the implementation of health rights related to actions by the Union Government. This would also include deliberations on the underlying structural and policy issues, responsible for health rights violations. Half of the members of this committee would be drawn from national level health sector civil society platforms. NHRC would facilitate this committee. Similarly, operationalising Sectoral Health Services Monitoring Committees dealing with specific health rights issues (Women's health, Children's health, Mental health, Right to essential drugs, Health rights related to HIV-AIDS etc.)

The structure and functioning of the Medical Council of India should be immediately reviewed to make its functioning more democratic and transparent. Members from Civil Society Organisations concerned with health issues should also be included in the Medical Council to conform medical education to serve the needs of all citizens, especially the poor and disadvantaged.

People's access to emergency medical care is an important facet of right to health. Based on the Report of the Expert Group constituted by NHRC (Dr. P.K.Dave Committee), short-term and long-term recommendations were sent to the Centre and to all States in May 2004. In particular, the Commission recommended:

(i) Enunciation of a National Accident Policy;
(ii) Establishment of a central coordinating, facilitating, monitoring and controlling committee for Emergency Medical Services

(EMS) under the aegis of Ministry of Health and Family Welfare as advocated in the National Accident Policy.

(iii) Establishment of Centralised Accident and Trauma Services in all districts of all states and union territories along with strengthening infrastructure, pre-hospital care at all government and private hospitals.

Spurious drugs and sub-standard medical devices have grave implications for the enjoyment of human rights by the people. Keeping this in view all authorities are urged to take concrete steps to eliminate them.

Access to Mental health care has emerged as a serious concern. The NHRC reiterates it's earlier recommendations based on a Study "Quality Assurance in Mental Health" which were sent to concerned authorities in the centre and in states and underlines the need to take further action in this regard.

Recommendations to State Governments / State Health Ministries:

Enactment of State Public Health Services Acts/ Rules, detailing and operationalising the National Public Health Services Act, recognizing and delineating the Health rights of citizens, duties of the Public health system and private health care providers and specifying broad legal and organizational mechanisms to operationalise these rights. This would include delineation of lists of essential health services at all levels: village/ community, sub-centre, PHC, CHC, Sub-divisional and District hospital to be made available as a right to all citizens. This would take as a base minimum the National Lists of essential services mentioned above, but would be modified in keeping with the specific health situation in each state.

These rules would also include special sections to recognise and protect the health rights of various sections of the population, which have special health needs: Women, children, persons affected by HIV/AIDS, persons with mental health problems, persons in conflict situations, persons facing displacement, workers in various hazardous occupations including unorganised and migrant workers etc.

Enacting State Clinical Establishments Rules regarding health rights concerning the private medical sector, detailing the provisions made in the National Act. Enactment of State Public Health Protection Acts that define the norms for nutritional security, drinking water quality, sanitary facilities and other key determinants of health. Such acts would complement the existing acts regarding environmental protection, working conditions etc. to ensure that citizens enjoy the full range of conditions necessary for health, along with the right to accessible, good quality health services.

Substantial increase in state budgetary provisions for public health to parallel the budgetary increase at central level, this would entail at least doubling of state health budgets in real terms by 2009.

Operationalising a State level health services monitoring mechanism, consisting of a *State Health Services Monitoring and Consultative Committee* to periodically review the implementation of health rights, and underlying policy and structural issues in the state. Half of the members of this committee would be drawn from state level health sector civil society platforms. Corresponding Monitoring and Consultative Committees with civil society involvement would be formed in all districts, and to monitor urban health services in all Class A and Class B cities.

Instituting a Health Rights Redressal Mechanism at State and District levels, to enquire and take action relating to all cases of denial of health care in a time bound manner.

A set of public health sector reform measures to ensure health rights through strengthening public health systems, and by making private care more accountable and equitable. The minimum aspects of a health sector reform framework that would strengthen public health systems must be laid down as an essential precondition to securing health rights. An illustrative list of such measures is as follows:

1. State Governments should take steps to decentralise the health services by giving control to the respective Panchayati Raj Institutions (PRIs) from the Gram Sabha up

HEALTH CENTRE LIBRARY AND DOCUMENTATION

to the district level in accordance with the XI Schedule of the 73rd and 74th Constitutional Amendment 52 of 1993. Enough funds from the plan and non plan allocation should be devolved to the PRIs at various levels. The local bodies should be given the responsibility to formulate and implement health projects as per the local requirements within the local overall framework of the health policy of the state. The elected representatives of the PRIs and the officers should be given adequate training in local level health planning. Integration between the health department and local bodies should be ensured in formulating and implementing the health projects at local levels.

2. The adoption of a state essential drug policy that ensures full availability of essential drugs in the public health system. This would be through adoption of a graded essential drug list, transparent drug procurement and efficient drug distribution mechanisms and adequate budgetary outlay. The drug policy should also promote rational drug use in the private sector.
3. The health department should prepare a State Drug Formulary based on the health status of the people of the state. The drug formulary should be supplied at free of cost to all government hospitals and at subsidized rate to the private hospitals. Regular updating of the formulary should be ensured. Treatment protocols for common disease states should be prepared and made available to the members of the medical profession.
4. The adoption of an integrated community health worker programme with adequate provisioning and support, so as to reach out to the weakest rural and urban sections, providing basic primary care and strengthening community level mechanisms for preventive, promotive and curative care.
5. The adoption of a detailed plan with milestones, demonstrating how essential secondary care services, including emergency care services, which constitute a basic right but are not available today, would be made universally available.
6. The public notification of medically underserved areas combined with special packages administered by the local elected bodies of PRI to close these gaps in a time bound manner.
7. The adoption of an integrated human resource development plan to ensure adequate availability of appropriate health human power at all levels.
8. The adoption of transparent non-discriminatory workforce management policies, especially on transfers and postings, so that medical personnel are available for working in rural areas and so that specialists are prioritised for serving in secondary care facilities according to public interest.
9. The adoption of improved vigilance mechanisms to respond to and limit corruption, negligence and different forms of harassment within both the public and private health system.
10. All health personnel upto the district PRI level must be administratively and financially accountable to the PRI at each level from the Gram Panchayat to the District level. Adequate financial resources must be made available at each level to ensure all basic requirements of health and medical care for all citizens.

Ensuring the implementation of the Supreme Court order regarding food security, universalising ICDS programmes and mid day school meal programmes, to address food insecurity and malnutrition, which are a major cause of ill health.

People's access to emergency medical care is an important facet of right to health. Based on the report of the expert group constituted by the NHRC (Dr. P.K.Dave Committee), short-term and long-term recommendations were sent to the Centre and to all States in May 2004. In particular, the commission recommended:

(i) Enunciation of a National Accident Policy;
(ii) Establishment of a central coordinating, facilitating, monitoring and controlling committee for Emergency Medical Services (EMS) under the aegis of Ministry of Health and Family Welfare as advocated in the National Accident Policy.
(iii) Establishment of Centralized Accident and Trauma Services in all districts of all States and various Union Territories along with strengthening infrastructure, pre-hospital care at all government and private hospitals.

Spurious drugs and sub-standard medical devices have grave implications for the enjoyment of human rights by the people. Keeping this in view all authorities are urged to take concrete steps to monitor and eliminate them.

Access to Mental health care has emerged as a serious concern. The NHRC reiterates its earlier recommendations based on a Study "Quality Assurance in Mental Health" which were sent to concerned authorities in the Centre and in States and underlines the need to take further action in this regard.

Recommendations to NHRC

NHRC would oversee the monitoring of health rights at the National level by initiating and facilitating the *Central Health Services Monitoring Committee* and at regional level by appointing *Special Rapporteurs on Health Rights* for all regions of the country.

Review of all laws/statutes relating to public health from a human rights perspective and to make appropriate recommendations to the Government for bringing out suitable amendments.

Recommendations to SHRCs

SHRCs in each state would facilitate the *State Health Rights Monitoring Committees* and oversee the functioning of the State level health rights redressal mechanisms.

Recommendations to Jan Swasthya Abhiyan and civil society organisations

JSA and various other civil society organisations would work for the widest possible raising of awareness on health rights – 'Health Rights Literacy' among all sections of citizens of the country.

Conclusion

Institutions like the NHRC are the only means, which theoretically at least, hold promise of affordable access to justice for the poor and the vulnerable which constitute at least one third of India's population. Institutions like the NHRC fill an important void in a poor person's search for justice. The real significance of the commission is advocacy, to build constant pressure and act as reminder of the state obligations towards the rights. Due to the commission's insistence these economic, social and cultural rights have acquired constant public discourse in evaluating the effectiveness of the Indian state. The courts are not sufficient in themselves because of the weak support structure for legal mobilisation. The view that courts and existing national institutions are sufficient to attend to the human rights agenda is based on the assumption that support for legal mobilisation is uniform throughout. In addition, the social composition is such that the poor and the vulnerable groups form significant components in these societies. These very social segments are hardly in a position to utilise the courts as an institution to full their fundamental rights, much less their economic, social and cultural rights. In such social settings institutions like the NHRC are very much needed to keep exclusive focus on need for fulfilment of these rights and internalisation of international human rights norms.

How to File Complaints with the Commission

- Complaints may be filed in Hindi, English or in any language included in the Eighth Schedule of the Constitution.
- The complaints are expected to be self contained.
- No fee is charged on complaints.
- The commission may ask for further information and affidavits to be filed in support of allegations whenever considered necessary.
- The commission may in its discretion, accept telegraphic complaints and complaints conveyed through FAX or by email.

National Human Rights Commission
Faridkot House,
Copernicus Marg, New Delhi - 110 001.
Facilitation Centre (Madad): (011) 23385368
Mobile No. 9810298900 (For complaints-24 hrs.)
Fax: (011) 23386521 (complaints)/23384863
Email: / jrlaw@nic.in(For complaints)
Web site: www.nhrc.nic.in

Thirteen

Other Cases

Adv. Mihir Desai and Adv. Kamayani Bali Mahabal

Introduction

Some important topics have not fallen in the purview of earlier chapters. Here we deal with how Indian courts have dealt with suicide and euthanasia; what they have ruled on the right to medical records and looked at service conditions of health professionals; on the Organ Transplantation Act and on issues of prisoners' health.

Euthanasia, Suicide and Related Issues

Does a person have a right to commit suicide? Can a doctor help a person to commit suicide? Can a doctor withdraw the life support system and thus allow a patient to die? Can a doctor supply drugs to help a patient die?

Under the Indian law, attempt to commit suicide is an offence. So are abetment to suicide and aiding a suicide.

Unlike in many other countries, in India attempt to commit suicide is a crime. In **P. Rathinam vs. Union of India**[1] the Supreme Court held that Section 309 of the Indian Penal Code that penalises suicide is unconstitutional and it struck down this provision. The Court held that the right to life guaranteed by Article 21 of the Constitution includes within it 'right not to live' and thus the right to commit suicide is part and parcel of the fundamental right to live. However, very soon, a larger Bench of the Supreme Court in the case of **Smt. Gian Kaur vs. State of Punjab**[2] overruled this decision and upheld the validity of Section 309 thereby again reviving the position under which attempt to commit suicide is treated as a crime. The Court held that 'right to life' did not include right to die. This was especially so if the natural course of life was being terminated. However, in matters concerning persons who were suffering from vegetative state or were terminally ill the Court observed that such a case since a person could no more be said to be living with human dignity, the taking away of life could be considered legal. While these observations are made by the Supreme Court it is not very clear whether the Supreme Court is permitting euthanasia. The observations are worth noting:

Protagonism of euthanasia on the view that existence in persistent vegetative state (PVS) is not a benefit to the patient of a terminal illness being unrelated to the principle of Sanctity of life' or the 'right to live with dignity' is of no assistance to determine the scope of Article 21 for deciding whether the guarantee of 'right to life' therein includes the 'right to die'. The 'right to life' including the right to live with human dignity would mean the existence of such a right up to the end of natural life. This also includes the right to a dignified life up to the point of death including a dignified procedure of death. In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out. But the 'right to die' with dignity at the end of life is not to be confused or equated with the 'right to

[1] AIR 1994 SC 1844
[2] (1996) 2 SCC 648

die' an unnatural death curtailing the natural span of life.

A question may arise, in the context of a dying man, who is, terminally ill or in a persistent vegetative state that he may be permitted to terminate it by a premature extinction of his life in those circumstances. This category of cases may fall within the ambit of the 'right to die' with dignity as a part of right to live with dignity, when death due to termination of natural life is certain and imminent and the process of natural death has commenced. These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death which has already commenced. The debate even in such cases to permit physician assisted termination of life is inconclusive. It is sufficient to reiterate that the argument to support the view of permitting termination of life in such cases to reduce the period of suffering during the process of certain natural death is not available to interpret Article 21 to include therein the right to curtail the natural span of life.

In the same judgment the Supreme Court unequivocally upheld the validity of Section 306 of the Indian Penal Code which penalises abatement to suicide.

The case of **C.A. Thomas Master vs. Union of India**[3] taken up by the Division Bench of the Kerala High Court involved peculiar facts. The Petitioner was an 80 year old man. He was well settled in life. He was living with his family which was treating him well. He did not suffer from any significant illnesses. He approached the Court saying that he had lived his life to the full and now wanted to die and donate his organs while they were still functioning. He needed the Court's permission to go ahead with his plans.

The Petitioner did not challenge the Constitutional validity of the provisions penalising suicide. But he made a distinction between suicides, which he said were committed by dissatisfied persons and the actions of a person like him who was happy and wanted to put an end to his life. His prayer was that the Government should set up voluntary death clinics for such persons. The main argument of the Petitioner concerned the difference between suicide as understood generally and the right to voluntarily put end to one's life.

The Court, however, held that there was no distinction between suicide and voluntarily putting an end to one's life. Suicide meant the voluntary putting an end to one's life and in the eyes of law the causes why such a decision was taken by a person were wholly irrelevant.

While the Courts are unequivocal in holding that the attempt to commit suicide and abetment to suicide are crimes there seems to be a hesitation in dealing with euthanasia. Ordinarily euthanasia will amount to a homicide and a doctor can be charged with murder but some observations of the Supreme Court do give an indication that it is willing to deal with terminally ill patients or patients in a vegetative state differently.

The issues concerning euthanasia have not been debated much in Indian courts, and by way of an example, we look at some of the U.K. decisions to ascertain the trend. In England, the attempt to commit suicide is not a crime but it is a crime to abet suicide. So the question of euthanasia has been widely debated in those Courts.

But the first question which initially baffled the Courts was if a competent and conscious patient refuses the administration of a treatment for preventing his death is the doctor bound to still provide the treatment? In **Re T (Adult refusal of Medical Treatment) case**[4] the Court held that patients have a right to refuse treatment even if, as a result, the patient would die. Giving such a patient treatment may even amount to the doctor committing trespass on his body. In another case **Re B (Adult: Refusal of Medical Treatment)**[5] the Court was concerned with a patient who was competent, conscious but was paralysed and on a ventilator for a number of years. She wanted the ventilator to be switched off but the doctors refused.

---

[3] 2000 CRLJ 3729
[4] 1992 4 ALL ER 649 affirmed in 2002 EWHC 429
[5] 2002 2 FCR 1

She approached the Court and the Court allowed the ventilator to be switched off.

The case of **Airedale National Health Service vs. Bland**[6] resulted in a leading decision on this issue given by the House of Lords. Bland suffered from major injuries and was in coma for three years. His doctors and relatives approached the Court for permission to switch off life support. The Court held that switching off the support system was in the nature of an omission rather than a positive act. By withdrawing the support system Bland was being returned to the position he was in when he first entered the hospital. The Court then held that the doctor's duty was to provide a patient with a treatment which was in his best interests. Continued treatment may not harm Bland but would not even benefit him and so was not in his best interests. The Court held that switching off the life support system in such cases did not amount to an offence. However, the Court did make a distinction between active and passive treatment. It observed:

It is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be...So to act is to cross the Rubicon which runs between- on the one hand the care of the living patient and on the other hand euthanasia- actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law.

Medical Records

The medical record, or health record, is a systematic documentation of a patient's medical history and care. The term 'medical record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.

Although medical records are traditionally compiled and stored by health care providers, personal health records maintained by individual patients have become more popular in recent years. When patients have undergone tests for HIV, their doctors must maintain separate records to prevent test results from being inadvertently disclosed with other records. They can be guided by existing regulations for medical termination of pregnancy concerning the custody of consent forms and maintenance of admission registers.

The only case traceable under medical records is that of **Raghunath Raheja vs. Maharashtra Medical Council**[7] and it *raised* an important issue concerning medical records. The high court held that when a patient or his relative demands case papers from the hospital or the doctor, such case papers had to be supplied to the patient or his relative. The hospitals or the doctors could not claim any confidentiality or secrecy concerning such papers.

The judges held that the provisions of the Maharashtra Medical Council Act, 1965 and the rules framed thereunder in 1967, provided for the same. The judges went on to say, "The hospital and doctors may be justified in demanding necessary charges for supplying copies of such documents to the patient or his relatives. We, therefore, direct the Maharashtra Medical Council to issue necessary circulars in this regard."

Service Conditions of Health Professionals

Seenath Beevi vs. State of Kerala[8] was concerned with conditions of service of nurses in hospitals. Nurses in some of the taluka hospitals Kerala High Court complained about having to perform 14 hours of duty for six days in a week and asked the Court to direct the Government to have nurses in three shifts of eight hours each. The State contented that this would cause tremendous financial strain to it. To begin with, the Court observed:

---

[6] 1993 AC 789
[7] Writ Petition No. 3720 of 1991 decided by the Bombay High Court on 11.1.96
[8] 2003 3 KLT 788

Facts stated in the Writ Petition, uncontroverted as they are, go to show that the work of a Nurse, especially in the Government Hospitals, is extremely arduous in nature. The sum and substance of the submission of the learned counsel is that attending such duties continuously for long hours is harmful to the physical as well as mental health of the Nurse, unsafe to the patient and likely to cause deleterious consequences.

The Court, after referring to various decisions of the Supreme Court, reaffirmed that the right to decent working conditions was part of the fundamental right to life. It further observed:

Therefore it can safely be held that rationalisation of working hours to make it just, reasonable and humane is the constitutional obligation of the State. Right to have such conditions of work is an integral part of the right to life under Article 21 of the Constitution.

The Court ordered that nurses must not be forced to work for more than eight hours a day and financial stringency is no ground for the State to abdicate this responsibility. The Court's final order had the following directions:

(i) There shall be a declaration that compelling the petitioner to be on duty continuously for 14 hours a day for 6 days consecutively in a week is illegal and unconstitutional.
(ii) The respondents are directed to introduce 3-shift duty system in the Government Hospital, Thirroorangadi, immediately and redress forthwith the grievance of the petitioner.
(iii) It is made clear that in the light of the declaration above made to the effect that the impugned action of the respondents is illegal and unconstitutional; the prevailing system of assigning duty for 14 hours continuously to the petitioner and other nursing staff shall not be continued. It follows that the respondents shall take expeditious steps to introduce a three-shift duty system for the nursing staff in all the hospitals.

In **C.L. Venkata Rao vs. Govt. of Andhra Pradesh,**[9] the Andhra Pradesh High Court was concerned with the issue of strikes by doctors and facilities in medical hospitals. The Court relied on the Medical Regulations framed under Section 20-A read with Section 33(m) of the Indian Medical Council Act, 1956. Regulation No. 2 in Chapter-2 lays down the duties of physicians to their patients. Regulation No. 2.4 lays down:

provisionally or fully registered medical practitioner shall not willfully commit an act of negligence that may deprive his patient or patients from necessary medical care.

Chapter 7 of these Regulations deals with misconduct and the acts of commission or omission on the part of a physician, which construe misconduct. Regulation No. 7.1 deals with violation of the Regulations. Regulation No. 7.24 lays down that:

If a physician posted in a medical college/ institution both as teaching faculty or otherwise shall remain in hospital/college during the assigned duty hours. If they are found absent on more than two occasions during this period, the same shall be construed as a misconduct if it is certified by the Principal/Medical Superintendent and forwarded through the State Government to Medical Council of India/ State Medical Council for action under these Regulations.

On the basis of these two provisions, the Division Bench came to the conclusion that doctors do not have a right to strike. However, since the strike had been withdrawn the Court directed that no action be taken against the striking doctors.

The Court also dealt with a second issue concerning the provision of emergency health care services in case doctors go on strike. The high court directed the State government to have an emergency plan ready in case doctors go on strike including opening up military and similar hospitals for common people during the strike. The court exhorted private hospitals to provide free treatment to poor patients in case of strike by government doctors.

The third issue was the one raised by doctors. They had argued that the government hospitals did not

[9] 2005 6 ALD 327 decided on 23.8.2005

have enough facilities. This included problems the lack of availability of drugs, inadequate teaching doctors, etc. The high court appointed a committee to go into these aspects and submit a report to the government.

Organ Transplantation Act

The Transplantation of Human Organs Act, 1994 is a recent law and the judicial decisions are few. It was enacted with a dual objective— to encourage voluntary donations of organs and to prevent commercial exploitation and organ trade. This law legalizes transplantation of human organs in cases of live donor, brain dead donors and donors who are considered dead in a conventional sense. The Act lays down detailed procedure for organ transplantation including setting up of various committees. Transplantation is permitted only in those hospitals which are specifically registered for the purpose.

In **Santosh Hospitals Pvt. Ltd. vs. State Human Rights Commission**[10] the Madras High Court was considering a case of a hospital registered for kidney transplants. The complainant had undergone a kidney transplantation at this hospital under a visiting surgeon. Under the law such transplantation is permitted only in cases of relatives or out of love and affection. The donor complained to the State Human Rights Commission that though the donee had agreed to pay him Rs. 1, 50,000 for his kidney he had been paid only Rs. 45,000. In the case it came out that the consent letter from the Authorisation Committee was a bogus one. The hospital tried to wash its hands off by arguing that it had only given surgical facilities to the doctor concerned and it was not otherwise concerned with this transplantation. The Human Rights Commission recommended a CID enquiry into the whole episode and further recommended that Rs. 30,000 be paid to the donor by the government. This order was challenged in the Madras High Court.

To begin with, the high court held that the State Human Rights Commission had no jurisdiction in the matter since its jurisdiction under the Act which set it up was confined to dealing with actions of public servants and neither the hospital was a public hospital nor was the doctor a public servant. Thus the court quashed the order of the State Human Rights Commission. However, the court felt that the issue was very important any way and directed the Authorities to investigate the matter and punish the culprits.

In **Balbir Singh vs. Authorisation Committee**[11] the Delhi High Court was concerned with a case of liver transplantation between two brothers. Due to the delays by the Authorization Committee by the time the case came up in court the patient was dead. But the court felt it the issue was important and thus went into the rival contentions. To begin with, it held that when transplantation is between near relatives there was no need to approach the Authorisation Committee. This was needed only when an outsider was involved. The court also set up a committee and observed that:

It is appropriate that a Committee be constituted to review the provisions of the Act and the Rules in the light of observations made in the judgment. The Committee to consider examines and gives its report to the Central Government on the following:—

1. Based on the date available on the transplantation of organs and the working of the. Authorization Committees, the Committee to examine and make its recommendations on the composition of Authorization Committees and changes, if any, required to ensure timely permissions.
2. Whether the jurisdiction of the Authorization Committees should be enlarged by bringing within its ambit the process of certifying a "near relative" or the task be assigned to another designated authority?
3. Review the provisions of the Act and Rules based on the experience of transplantation of organs as carried out and the difficulties arising due to the bottlenecks faced in the said process. The Committee to examine in particular provisions of Section 9 and requirement of

[10] AIR 2005 MAD 348
[11] AIR 2004 DEL 413

carrying out the tests prescribed in Rule 4, certification in Form 3 to review the definition of "near relative" and make its recommendations in the light of the observations made :—

4. Examine and specify the organs for transplantation of which the tests prescribed in Rule 4(1) (c) to establish the factum of being "near relative" need not be carried out when other evidence is available.
5. Examine the feasibility of establishing and setting up Organ Procurement Organizations with data bank to facilitate the dissemination of information on availability of organs for transplantation. To encourage organ donation especially from cadavers, cases of brain-stem deaths and other deceased persons, who had authorized removal of organs upon demise.
6. Examine the feasibility of creation of a fund, the corpus to be provided partly come from the Union of India and partly by levying a fixed charge on the total bill of the hospital for transplantation and/or public donations, for providing to a donor social incentives, medical aid and facility of transplantation of organ in future, should the same be required.
7. Examine and recommend ways and means to give social incentives, including but not limited, to help and aid and preferred health care, recognition and honour to a donor in the community.
8. Examine the causes that lead to exploitation of poor and unaware persons in the process of organ donation and suggest methods to reduce control and ultimately eradicate such mal-practices. Recommend programmes for dissemination of correct information of ethical, legal and devising procedure concerning organ donation so that a conducive atmosphere is generated and disinformation and misgivings are dispelled.
9. Any other matter relevant to the subject.

The composition of the Committee shall be the following:-

(i) Secretary, Ministry of Health or his nominee being an officer not less than the rank of Additional Secretary, Ministry of Health, as the Convenor.
(ii) Director General of Health Services or the Addl. Director General of Health Services as the Member Secretary.
(iii) The Head of Department of Surgery, AIIMS;
(iv) Dr. Harsh Johri, Renal Surgeon, Sir Ganga Ram Hospital,
(v) Secretary of the All India Medical Association; and
(vi) Mr. Sanjay Jain, Advocate, Chamber No. 488, New Chambers Block, Delhi High Court, New Delhi.

The Committee to give its report and recommendations to the Government within four months. Copy of the same be placed on record.

S. Malligamma vs. State of Karnataka[12] is a disturbing judgment. Live organ donations are permitted either in cases of near relatives or when it is done out of love and affection. This is to prevent widespread sale of kidneys by poor persons. Whether there exists a relationship of love and affection has to be decided by the Authorisation Committee. It was a case of kidney donation where the donors and donees were not related. They were not from the locality or place of origin and they were not from the same caste. The Authorisation Committee and the Single Judge of the high court rejected the application as there was no proof of any nature that the transplantation arose out of any love and affection between the parties, which is the legal requirement. The Division Bench, however, in effect allowed the transplantation by holding that if there was no proof of coercion such transplantation has to be allowed. This is clearly contrary to the mandate of the law which is not based on absence of coercion but a positive relationship of love and affection.

Prisoners' Health

There are innumerable judgements of Supreme Court and high courts, showing how prisoners' rights are violated. Some of them related to health care are mentioned here. The judgements highlight the highly unsatisfactory conditions prevailing inside prisons and the failure of the prison authorities to provide an environment which is

[12] ILR 2005 KAR 1557

conducive to the maintenance of prisoners' rights, partly rooted in the belief that the prisoners do not deserve all the rights and the protections that the Constitution provides to all citizens. Besides being morally wrong and legally invalid, this belief does not show adequate recognition of some basic facts about the prison population.

In **Ramamurthy vs. State of Karnataka**[13] the Supreme Court stated that

...the century old Indian Prison Act, 1894 needs a thorough look and is required to be replaced by a new enactment which would take care of the thinking of Independent India and our constitutional mores and mandate.

The Supreme Court noted

The Court observed that Society has an obligation towards prisoner's health for two reasons: firstly, the prisoners do not enjoy the access to medical expertise that free citizens have. Their incarceration places limitations on such access, choice of physician, modes of taking second opinion, and access to any specialist. Secondly, because of the conditions of their incarceration, inmates are exposed to more health hazards than free citizens. Prisoners therefore, suffer from a double handicap.

The petition **Tapas Kumar Bhanja vs. State of West Bengal and Anr**[14] was filed in 2000 by a public-spirited lawyer Tapas Kumar Bhanja. This was predominantly a complaint regarding a home called 'Liluah Home' for undertrial women. The grievance made in the petition was that there was over all mismanagement in this Home; that the lady prisoners were not at all safe, injustices were perpetrated; they were physically and mentally molested; they were not even provided elementary medical treatment, and that there was overall mismanagement. It was also pointed out that the number of women prisoners escaped from the Home not to be found again. This was a case where there was a gross abuse of human rights.

In **CEHAT vs State of Maharashtra and Ors**[15], the petitioners asked for the formation of a committee comprising a dietician and doctor to review the diet scales for prisoners in the jail, as their was discrimination being practised in jails based on the origin of the inmates. The court formed a committee and asked them to recommend new or modified diet scales based on physical needs and not on origin of prisoners. The committee suggested separate diet scales for males and females alongwith pregnant and nursing women and children. The state government agreed to implement the recommendations of the committee. The court also directed the jail authorities to follow rule 37 of the Maharashtra prison diet 1970 strictly. According to the rule a prisoner convict or undertrial should be given court before the laves for his hearing to the court and incase he is not been to prison it is the duty of the officer to provide whim with food if he will reach prison late after the hearing of his case.

In response to a public interest litigation dealing with undertrial prisoners, **R D Upadhyaya vs. State of AP**, [16]the Supreme Court carried out an in-depth examination of the issue and gave extensive directions with regard to the children of women prisoners, in a judgment delivered on April 13, 2006. The court took note of various provisions in the Constitution as well as laws enacted for the benefit of children.

The court referred to a study on children of women prisoners in India, carried out by the National Institute of Criminology and Forensic Sciences. The salient features of this study are:

- Most children were living in difficult conditions and suffered deprivation relating to food, healthcare, accommodation, education and recreation.
- There were no programmes for the proper bio-psycho-social development of children in prisons. Their welfare was mostly left to the mothers. There was no trained staff to take care of the children.

---

[13] (1997) 2 SCC 642, Writ Petition (C) No. 12223 of 1984 decided on: 23.12.1996
[14] (2006) 2 CAL LT 108(HC)
[15] Writ Petition No 3047 of 2004 decided on April, 20th 2005
[16] 2006 (4) SCALE 336

- In many jails, women inmates with children were not given any special or extra food. In some jails, extra food was given in the form of a glass of milk; in others, separate food was being provided only to children over the age of five. The quality of food supplied was the same as that given to adult prisoners.
- No special consideration was given to child-bearing women. The same food and facilities were given to all women, irrespective of whether their children were living with them or not.
- No separate or specialised medical facilities for children were available in jails.
- Most mother prisoners felt that the stay in jail would have a negative impact on the physical and mental development of their children.
- A crowded environment, lack of appropriate food and shelter, deprivation of affection by other members of the family, particularly the father, were perceived as stumbling blocks in the development of these children in their formative years.
- Mother prisoners identified food, medical facilities, accommodation, education, recreation and the separation of children from habitual offenders as six areas that require urgent improvement.
- There were no prison staff specially trained to look after children in jails. Also, no separate office with the exclusive duty of looking after the children or their mothers.

Firstly, the judgment makes clear that a child shall not be treated as an undertrial/convict while in jail with his/her mother. Such a child is entitled to food, shelter, medical care, clothing, education and recreational facilities as a matter of right. The Court directed that before sending a pregnant woman to jail, the authorities must ensure that the jail has the basic minimum facilities for delivery as well as prenatal and post-natal care for both mother and child. If a woman prisoner is found to be pregnant at the time of her admission, or afterwards, arrangements must be made to get her examined at the district government hospital. The state of her health, pregnancy and probable date of delivery should be ascertained and proper prenatal and post-natal care provided in accordance with medical advice.

The Supreme Court has laid down uniform guidelines applicable to all prisons in the country: Female prisoners will be allowed to keep their children with them in jail until they attain the age of six years. After the age of six, the child will be handed over to a surrogate, in accordance with the mother's wishes, or put in an institution run by the social welfare department. Children above the age of six must be put in an institution in the same city as the prison and must be allowed to meet the mother at least once a week. In case a female prisoner dies leaving behind a child, the district magistrate must arrange for the child to be properly looked after, either by a concerned relative or a responsible person, or admitted in a social welfare department home.

The non-availability of adequate medical facilities for prisoners is largely due to the lack of full time doctors as well as lack of basic infrastructure, like well-equipped ambulances, stretchers, dispensaries, hospital beds etc. Sometimes, the prisoner may need expert and urgent medical attention which is not available within the jail premises. The present day medical setup of the prisons in the districts need to be updated to such an extent that only in the complicated cases the patients are required to be referred to super specialty hospitals or the civil hospitals. It clearly appears to us that the present day setup is very poor and the prisoners deserve better treatment and better facilities.

Fourteen

Trends in Judicial Outcomes and Consequences for Health Care

Adv. Mihir Desai

The last two decades have seen a phenomenal rise (compared to the earlier decades) in litigation concerning the health of individuals of communities and society at large. An obvious off shoot of these developments has been litigation concerning health care. However, before we see the recent trends it becomes crucial to look at the trends concerning health care in the first three decades after independence.

Till the early 1980s, the judicial response to health related issues in India was essentially centered around cases of medical negligence or entitlements of employees under the Workmen's Compensation and ESI Acts. Apart from this, there were a few cases concerning drugs and other related issues.

Under the welfares policies of the government many labour laws were enacted. Some of them dealt with health and health care. In the last 50 years, a majority of the decisions under these laws have been concerned with a very limited range of issues. Employees who suffer injury at the workplace are entitled to compensation. A large number of cases are around disputes about whether a disease or injury was acquired during the course of employment or not. The second type of controversy has been around whether a particular employer or employee falls within the mandate of the Acts under which protection is sought. The third major area of dispute has been the quantum of compensation to which an employee would be entitled. In recent times the courts have played a more proactive role and have laid down strict conditions of health and safety for the workmen like it was done by the Supreme Court in the case of asbestos manufacturing industry.

But it must be borne in mind that there are a relatively smaller numbers of employees governed by health care legislation in the private sector. Besides, in recent times the attitude of the courts towards these employees has not been very positive. For instance, recently the Supreme Court held that a casual workman is not covered under the Workman's Compensation Act.

The second branches of litigation concerning employees are cases regarding government servants. A large number of these cases pertain to the rights of government employees to reimbursement of medical expenses incurred in private health care sector. At around this time patients started approaching the courts in matters concerning medical negligence. They were required to file suits in the district courts, which were highly time consuming, expensive and in many cases resulted in failure. The law followed in these matters was the English common law (judge made law) concerning torts and more particularly negligence. Though the legal tools to fight against medical negligence have always been available, the procedural tools were highly inadequate. So the cases were few. This situation changed dramatically from the mid 1980s with the passage of the Consumer Protection Act and a consequent decision of the Supreme Court that medical services (except those providing totally free medical services) were covered under the Act.

On matters of negligence the development of litigation has been quite phenomenal. Of course, the legal principles on this issue remain the same as they were more than 50 years ago. It is necessary to show duty to take care; it is important

to point out the standard of care required; and, it is crucial to establish the linkage between negligence and injury. Even so, the courts have started utilizing some recently derived principles such as informed consent. On the other hand, the Supreme Court in recent times has whittled down criminal responsibility of doctors by holding that doctors could not be held criminally liable unless they are guilty of 'gross' negligence. Besides, police complaints cannot be filed without another doctor's opinion concerning negligence. Such opinions are very difficult to obtain. Although victims of medical negligence have the option of also approaching medical councils, their experience, with these Councils has, by and large, been negative. The general feeling is that medical councils are overprotective of doctors.

Drugs and Cosmetics Laws have been existence since before independence. Judicial decisions under these laws have been mainly in respect of licensing conditions and classification of various items as drugs. The courts have not often interfered with the strict licensing conditions concerning drug manufacture, storage and distribution. They have also given a broad definition to the term 'drug' preventing escape route for manufacturers from strict quality control. The next decade, will of course witness gruelling battles on drug patents. With product patents being now available coupled with strategic ever greening of patents by large pharma industries there are likely to be pitched legal battles between patient rights groups, state and the industry.

In recent years there has also been a large amount of litigation concerning the right to practice medicines by people holding qualifications not recognized under the law. Since the 1980s with the rapid privatisation of medical education many unaffiliated, unrecognised colleges have cropped up offering diplomas and degrees in branches of medicines not recognised under the law. Instances of these are electropathy and electro homeopathy. Gullible students take these courses paying high fees only to realise later that these qualifications have not been duly recognised by any authority. The courts have consistently refused to interfere in these matters and have disallowed such persons from practising medicine. However, the courts have acknowledged the power of State governments to recognize certain qualifications on their own merits. Courts have also come down heavily against cross practice in medicine.

The 1990s saw litigation in two new branches of health care law. First has been in respect of the law concerning HIV/AIDS. Though as yet there has been no central law relating to this, the courts have intervened in matters concerning the rights of HIV positive persons especially in employment related laws and through the use of the right to life to include the right to live with human dignity. The development in this area of law has been very interesting. In the 1980s when there was little awareness about this issue, the courts were inclined to focus on protecting society from HIV positive persons. But in the 1990s with a growing understanding of the issue the courts have stepped in to protect the confidentiality of positive persons, prevent discrimination in employment and other aspects of life. In the next few years, we are likely to witness a proliferation of litigation concerning this branch of law, especially if the new law in the making rolls out.

Similarly, after the enactment of the Organ Transplantation Act in the 1990s some amount of litigation emerged on the issue. The litigation till now has been around the issue of who can donate organs. But as cadaver transplantation becomes more popular, a plethora of issues under this law are likely to arise.

Euthanasia is not recognised in India. However, debates have started on this issue and one can foresee some litigation on this controversial issue.

Another area where perspectives have changed over a period concerns mental health. From treating mentally ill patients as those who deserve to be locked up and forgotten the perspective now is much more sensitive and favourable to them. This is also reflected in the Disabilities Act passed in the 1990s. Earlier the law as well as litigation concerned rights vis a vis the mentally ill. Now it is increasingly tending to be a perspective of the rights of disabled persons. Even so, the main area of litigation in this branch has been around conditions of homes for the mentally ill and their

confinement in prisons. However, with the passage of time and more awareness of the complexities of the problem courts are likely to be more frequently approached.

Women's health as a separate subject was always recognised through various provisions in the Factories Act, laws concerning abortion and the Maternity Benefit Act. But the special importance of women's reproductive rights emerged in the 1980s after struggles of women's groups on the use of women as guinea pigs for testing contraceptives. The courts have been called upon to restrain such experiments. The courts have been approached for failure of sterilization operations but in these matters they have, by and large, refrained from interfering.

In the only case relating the Right to Food currently pending in the Supreme Court, **(P. U. C. L. vs. State of W. B. & Ors.)** the Court has been satisfied with giving certain directions so as to see that people do not die for the want of food. The Right to Food includes the Right to Health and Health-care and it is not merely the right to receive food in terms of minimum calories, but, it includes the Right to Adequate Food. The adequacy will then be measured by not only what is necessary for survival, but by a person's health or by his ability to pursue a normal active existence. The concept of adequate food for the maintenance of health, not only requires a minimum calorific intake but also a certain balance of nutrients. The Right to Food should be understood together with a range of other rights – access to health care, medical facilities, drinking water and sanitary facilities. Unfortunately, the Supreme Court has not yet laid down the inter-relationship between Right to Food and Right to Health.

Public Interest Litigation, Fundamental Right and its Consequences

Two developments in the 1980s led to a marked increase in health related litigation. First was the establishment of consumer courts making the suing of doctors and hospitals for medical negligence and deficiency in service easier and cheaper. Second was the growth of public interest litigation, an expanded interpretation of the Right to Life as a fundamental right and one of its off shoots being the recognition of health and health care as a fundamental right.

The public interest litigation movement in India began in late 1970s. Its foundation is the enforcement of fundamental rights guaranteed under the Constitution of India. Any citizen could trigger off the judicial mechanism by claiming a violation of Fundamental Rights, either of himself or of other individuals or of the citizenry at large. Fundamental Rights existed even before the late 1970s. The real push for the PIL movement came from an expanded interpretation of the Fundamental Right to Life which is enshrined in Article 21 of the Constitution. This reads:

No person shall be deprived of his life or personal liberty except through procedure established by law.

Till the 1970s, by and large, the courts had interpreted 'life' literally i.e. right to exist. The late 1970s onwards an expanded meaning started to be given to the word 'life'. Over the years it has come to be accepted that life does not only mean merely animal existence but the life of a dignified human being with all its concomitant attributes. This has been interpreted to include a healthy environment and effective health care facilities.

As we have seen in earlier Chapters to begin with, the right to health as a fundamental right grew as an off shoot of environmental litigation. Pollution free environment as a fundamental right presupposes the right to health as a Fundamental Right. Logically, the explicit recognition of the fundamental right to health should have preceded the fundamental right to good environment. However, the development of jurisprudence in this branch has been the reverse. To begin with, the right to decent environment was recognised and from that followed the right to public health, health and health care. Even while dealing directly with the right to health, the first issues concerned employees' health within a work place.

It was only in 1991, in **C.E.S.C. Ltd. vs. Subhash Chandra**[1] that the Supreme Court placed reliance on international instruments and declared that the right to health was a fundamental right.

The question, however remains whether a particular right is a positive or a negative right. A negative right is one which does not require the State to take any positive steps for its realisation but only needs the State to ensure that no actions are taken that deprive the person of the right. For instance, a negative right to health would mean that the state should ensure that there is no pollution or that the drugs supplied by companies are of good quality. On the other hand, a positive right would mean that the State should build hospitals, ensure provision of drugs at cheap rates, etc. While the Supreme Court has on occasion implicitly held that the right to health was a positive right, on most occasions its treatment has been as a negative right.

In **Vincent Panikurlangara vs. Union of India,** AIR 1987 SC 990 - (1987) 2 SCC 165, the Supreme Court observed "In a welfare State, therefore, it is the obligation of the State to ensure the creation and the sustaining of conditions congenial to good health."

Because of having recognized that right to health and health care as a fundamental right what follows? Fundamental rights are generally available only against the state. They prescribe the obligations of the State. In a poverty ridden country like India, does it mean that the State must provide free medical health care facilities to all? In a situation where there is increasing privatisation of the health care systems, where the proportional annual budget for health is shrinking, where the cost of health education is growing exponentially this seems very unlikely. No court has yet said that the State is bound to provide free medical care to all the citizens. This would be the consequence if the right to health care was recognised as a positive right.

The other aspect would, of course, be the quality of health care provided by the State. Infrastructure does not just comprise primary health care centres but even in government run hospitals in metropolitan cities service is crumbling. These institutions are plagued by a lack of enough beds, sufficient medicines and other similar problems. The Courts including the Supreme Court have not adequately dealt with this aspect. They have mainly been concerned with pious declarations of health being a fundamental right and peripheral and not so peripheral issues such as the rights of government employees to be treated in government hospitals, emergency medical care and the like.

Even in respect of emergency health care, the private sector has not yet come within the sweep of the Courts. In the case of **Paschim Banga Khet Mazdoor Samiti vs. State of W.B.,**[2] the Supreme Court observed that providing adequate medical facilities was an essential part of the obligation undertaken by the State in a welfare state. And failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in the violation of his right to life guaranteed under Article 21.

Although the responsibility of the State and government hospitals is well provided by a radical interpretation of the Constitution, there is no definite corresponding legal duty imposed on private hospitals and practitioners to treat emergency cases. The judgments mainly focus on the duty of the State and the government hospitals. Of course, in respect of medico legal cases, the Supreme Court has held that doctors are obliged to treat medico legal patients in without insisting on prior paper work in both private and public sector.

The Supreme Court and the high courts have been intervening in a much more active manner in the last few years on the issue of health and health

[1] AIR 1992 SC 573
[2] (1996)4 SCC 37

care. But again, unless they start looking into the impact of patents and drug price control as also the obligations of private hospitals, the effect is bound to be limited. The Bombay and Delhi High Courts have already started looking into this issue, but unless there is a national level focus on the responsibilities of private health care providers the impact of judicial decisions is likely to be only marginal.

It is time that private hospitals were made amenable to writ jurisdiction of high courts and the Supreme Court. This is crucial because individuals and groups can then approach the high court and Supreme Court directly regarding their grievances. They can claim that even private hospitals are subject to fundamental rights and liable for various social obligations concerning health care. Education, even in the private sector is held so susceptible. The Supreme Court has held that education is a sovereign function and even when it is being carried out in the private sphere it is a mere extension of the sovereign function and thus bound by various State mandates. There is no reason why health care should not be treated similarly as a sovereign function and the private sector seen as an extension of the State and thus subject to fulfilling its obligation towards the citizens.

In the coming decades a number of issues that will have a significant impact on the right to health and health care are likely to arise. Some of them are as follows:

- Interpretation and implementation of the new patent regime and its impact on availability and pricing of drugs
- Obligation of private hospitals towards poor persons
- Reducing role of the state sector in providing health care and its impact on the fundamental right to health care
- The shrinking regime of Drug Price Controls
- Legality of Euthanasia
- Conditions of public health care institutions including hospitals and primary health care centre

In the last 15 years there has been a major proliferation of litigation especially in the higher courts on health care issues of diverse varieties. Health and health care have been recognised as fundamental rights but the significance and implications of this recognition are yet to unfold. The next few years will be the testing time for the judiciary because if the right to health care has to be recognised and realised in a meaningful way the courts will have to clearly spell out the obligations of the State in providing health care facilities and will also have to bring within their net private health care providers as well as the powerful pharma industry.

Health is a social, economic and political issue and above all a human right. Inequity and poverty are the root cause of ill health leading to malnutrition and starvation deaths in the marginalized sections of the society. The current health scenario favours the urban affluent class, which is only about 10 per cent of the total population. There is a need to remove regional imbalances. Declining health expenditures have adversely affected health outcomes worsening the health scenario. There is a need to restructure the existing health system. The highly privatised health system has deprived the masses of even primary health care leading to out-of-pocket expenditure, which they can ill-afford. The National Health Policies did not achieve their targets thus creating a need for a comprehensive legislative framework. The existing health system needs to be restructured to usher equity and social justice. This can be achieved through the promulgation of a comprehensive legislative framework, which should create conditions conducive to restoring balance in the health sector. The legislation should be complemented by making the 'Right to Health Care' a fundamental right, which will be an enforceable right. The ultimate aim of Universal Access to Health Care could be achieved through the restructuring of health finance and the introduction of universal coverage of health care.[3]

---

[3] See Policy Brief- Moving towards Right to Health Care, published by CEHAT 2005 available at www.cehat.org

Fifteen

Towards Establishing the Right to Health and Healthcare

Ravi Duggal

The right to healthcare is primarily a claim to an entitlement, a positive right, not a protective fence.[1] As entitlements rights are contrasted with privileges, group ideals, societal obligations, or acts of charity, and once legislated they become claims justified by the laws of the state. [Chapman, 1993]. The emphasis thus should not be as much on 'respect' and 'protect' as on 'fulfill'. For the right to be effective optimal resources that are needed to fulfill the core obligations have to be made available and utilized effectively.

Further, using a human rights approach also implies that the entitlement is universal. This means that there is no exclusion from the provisions made to assure healthcare on any grounds whether purchasing power, employment status, residence, religion, caste, gender, disability, and any other basis of discrimination.[2] But this does not discount the special needs of disadvantaged and vulnerable groups, which may need special entitlements through affirmative action to rectify historical inequities from which they have suffered.

Establishing universal healthcare through the human rights route is the best way to fulfill the obligations mandated by international law and domestic constitutional provisions. International law, specifically ICESCR, the Alma Ata Declaration, among others, provide the basis for the core content of the right to health and healthcare. But country situations are very different and hence there should not be a global core content, it needs to be country specific.[3]

In India's case, the trajectory followed has been through the policy route and we have an existing baggage that we need to sort out and fit into the new strategy. To establish the right to health and healthcare in this context certain essential steps are immediately necessary:

- Equating directive principles with fundamental rights through a constitutional amendment.
- Incorporating a National Health Act (like, for example, the Canada Health Act) that will organize the present healthcare system under a common umbrella organization as

---

[1] In the 18th century rights were interpreted as fences or protection for the individual from the unfettered authoritarian governments that were considered the greatest threat to human welfare. Today democratic governments do not pose the same kind of problems and there are many new kinds of threats to the right to life and well being [Chapman, 1993]. Hence in today's environment reliance on mechanisms that provide for collective rights is a more appropriate and workable option. Social democrats all over Europe, in Canada, Australia have adequately demonstrated this in the domain of healthcare.

[2] A human rights approach would not necessitate that all healthcare resources be distributed according to strict quantitative equality or that society attempt to provide equality in medical outcomes, neither of which would in any case be feasible. Instead the universality of the right to healthcare requires the definition of a specific entitlement be guaranteed to all members of our society without any discrimination. [Chapman, 1993]

[3] Country specific thresholds should be developed by indicators measuring nutrition, infant mortality, disease frequency, life expectancy, income, unemployment and underemployment, and by indicators relating to adequate food consumption. States should have an immediate obligation to ensure the fulfillment of this minimum threshold. [Andreassen et.al., 1988 as quoted by Toebes,1998]

a public-private mix governed by an autonomous national health authority that will also be responsible for bringing together all resources under a single-payer mechanism.
- Generating political commitment through consensus building on right to healthcare in civil society.
- Development of strategy for pooling all financial resources deployed in the health sector.
- Redistribution of existing health resources, public and private, on the basis of standard norms (these would have to be specified) to assure physical (location) equity.

While the above are essential steps for establishing the right to healthcare they involve a process that will take some time. As an immediate step, within its own domain, the State should undertake to accomplish the following:

- Allocation of health budgets as block funding, that is, on a per capita basis for each population unit of entitlement as per existing norms. This will redistribute current expenditure and reduce substantially inequities based on residence.[4] Local governments should be given the autonomy to use these resources as per local needs but within a broadly defined policy framework of public health goals.
- Strictly implementing the policy of compulsory public service by medical graduates from public medical schools, as also make public service of a limited duration mandatory before seeking admission for post-graduate education. This will increase human resources with the public health system substantially and will have a dramatic impact on the improvement of the credibility of public health services.
- Essential drugs as per the WHO list should be brought back under price control (90 per cent of them are off-patent) and/or volumes needed for domestic consumption must be compulsorily produced so that availability of such drugs is assured at affordable prices and within the public health system.
- Local governments must adopt location policies for setting up hospitals and clinics as per standard acceptable ratios, for instance one hospital bed per 500 population and one general practitioner per 1000 persons. To restrict unnecessary concentration of such resources in over-served areas fiscal measures to discourage such concentration should be instituted.[5]
- The medical councils must be made accountable to assure that only licensed doctors practice the medicine that they are trained in.[6] Such monitoring is the core responsibility of the council by law, which they are not fulfilling, and as a consequence failing to protect the patients who seek care from unqualified and untrained doctors. Further continuing medical education must be implemented strictly by the various medical councils and licenses should not be

---

[4]To illustrate this, taking the Community Health Centre (CHC) area of 150,000 population as a "health district" at current budgetary levels under block funding this "health district" would get Rs. 30 million (current resources of state and central govt. combined is over Rs.200 billion, that is Rs. 200 per capita). This could be distributed across this health district as follows: Rs 300,000 per bed for the 30 bedded CHC or Rs. 9 million (Rs.6 million for salaries and Rs. 3 million for drugs and other consumables, maintenance, POL etc..) and Rs. 4.2 million per PHC (5 PHCs in this area), including its sub-centres and CHVs (Rs. 3.2 million as salaries and Rs. 1 million for drugs, consumables etc..). This would mean that each PHC would get Rs. 140 per capita as against less than Rs. 50 per capita currently. In contrast a district headquarter town with 300,000 population would get Rs. 60 million, and assuming Rs. 300,000 per bed (for instance in Maharashtra the current district hospital expenditure is only Rs. 150,000 per bed) the district hospital too would get much larger resources. To support health administration, monitoring, audit, statistics etc, each unit would have to contribute 5per cent of its budget. Of course, these figures have been worked out with existing budgetary levels and excluding local government spending which is quite high in larger urban areas. [Duggal,2002]

[5] Such locational restrictions in setting up practice may be viewed as violation of the fundamental right to practice one's profession anywhere. It must be remembered that this right is not absolute and restrictions can be placed in concern for the public good. The suggestion here is not to have compulsion but to restrict through fiscal measures. In the UK under NHS, the local health authorities have the right to prevent setting up of clinics if their area is saturated.

[6] For instance the Delhi Medical Council has taken first steps in improving the registration and information system within the council and some mechanism of public information has been created.

renewed (as per existing law) without the required hours and certification.

- Integrate ESIS, CGHS and other such employee based health schemes with the general public health system so that discrimination based on employment status is removed and such integration will help more efficient use of resources. For instance, ESIS is a cash rich organization sitting on funds collected from employees (which are parked in debentures and shares of companies!), and their hospitals and dispensaries are grossly under-utilised. The latter could be made open to the general public
- Strictly regulate the private health sector as per existing laws, but also make an effort to change these laws to make them more effective. This will contribute to the improvement of the quality of care in the private sector as well as create some accountability
- Strengthen the health information system and database to facilitate better planning as well as facilitate audit and accountability.

Carrying out these immediate steps will create the basis to move in the direction of the first essential steps indicated above. In order to implement the first steps the essential core contents of health care have to be defined and made legally binding through the processes of the first steps.

Literature and debate on the core contents is quite vast and from that we will attempt to draw out the core content of right to health and health care keeping the Indian context discussed above in mind. Audrey Chapman, in discussing the minimum core contents, summarises this debate

Operatively, a basic and adequate standard of healthcare is the minimum level of care, the core entitlement that should be guaranteed to all members of society: it is the floor below which no one will fall.[7] [Chapman, 1993].

She further states that the basic package should be fairly generous so that it is widely acceptable to people; it should address special needs of special and vulnerable population groups like under privileged sections (SC and ST in India); women, physically and mentally challenged, elderly etc.; it should be based on cost-conscious standards but judgements to provide services should not be determined by budgetary constraints,[8] and it should be accountable to the community as also demand the latter's participation and involvement in monitoring and supporting it. All this is very familiar terrain, with the Bhore Committee saying precisely this way back in 1946.

We would like to put forth the core content as under:

Primary care services[9] should include at least the following:

- General practitioner/family physician services for personal health care.
- First level referral hospital care and basic specialty and diagnostic services (general medicine, general surgery, obstetrics and gynaecology, paediatrics and orthopaedic), including dental and ophthalmic services.
- Immunisation services against all vaccine preventable diseases.
- Maternity and reproductive health services for safe pregnancy, safe abortion, delivery and postnatal care and safe contraception.
- Pharmaceutical services - supply of only rational and essential drugs as per accepted standards.

---

[7] This implies that the health status of the people should be such that they can atleast work productively and participate actively in the social life of the community in which they live. It also means that essential healthcare sufficient to satisfy basic human needs will be accessible to all, in an acceptable and affordable way, and with their full involvement. [WHO, 1993].

[8] General Comment 3 of ICESCR reiterates that the minimum core obligations by definition apply irrespective of the availability of resources or any other factors and difficulties. Hence it calls for international cooperation in helping developing countries that lack resources to fulfill obligations under international law.

[9] Most of at least the curative services will of necessity have to be a public-private mix because of the existing baggage of the health system we have but this has to be under an organized and accountable health care system.

- Epidemiological services including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures.
- Ambulance services.
- Health education.
- Rehabilitation services for the physically and mentally challenged and the elderly and other vulnerable groups
- Occupational health services with a clear liability on the employer
- Safe and assured drinking water and sanitation facilities, minimum standards in environmental health and protection from hunger to fulfill obligations of underlying preconditions of health.[10]

The above components of primary care are the minimum that must be assured, if a universal health care system has to be effective and acceptable. And these have to be within the context of first-steps and not to wait for progressive realisation – these cannot be broken up into stages, as they are the core minimum and hence non-negotiable. The key to equity is the existence of a minimum decent level of provision, a floor that has to be firmly established. However, if this floor has to be stable certain ceilings will have to be maintained very strictly, especially on urban health care budgets and hospital use [Abel-Smith, 1977]. This is important because human needs and demands can be excessive and irrational. Those wanting services beyond the established floor levels will have to seek it outside the system and/or at their own cost. However this does not mean that higher levels of care should not be part of the core contents. Access to specialist and tertiary services via primary care referral has to also be made part of the chain without any direct cost to the user.

Therefore it is essential to specify adequate minimum standards of health care facilities, which should be made available to all people irrespective of their social, geographical and financial position. There has been some amount of debate on standards of personnel requirements (doctor: population ratio, doctor: nurse ratio) and of facility levels (bed: population ratio, PHC: population ratio) but no global standards have as yet been formulated though some ratios are popularly used, like one bed per 500 population, one doctor per 1000 persons, three nurses per doctor, public health expenditure to the tune of 5 per cent of GDP, etc.. Another way of viewing standards is to look at the levels of countries that already have universal access systems in place. In such countries one finds that on an average per 1000 population there are two doctors, five nurses and as many as 10 hospital beds [OECD,1990, WHO,1961]. The moot point here is that these ratios have remained more or less constant over the last 30 years indicating that some sort of an optimum level has been reached.

In India the Bureau of Indian Standards (BIS) has worked out minimum requirements of personnel, equipment, space, amenities, etc for hospital care.. For doctors they have recommended a ratio of one per 3.3 beds and for nurse one per 2.7 beds for three shifts [BIS 1989, and 1992]. Again way back in 1946 the Bhore Committee had recommended reasonable levels (that at that time were about half that of the levels in developed countries) to be achieved for a national health service, which are as follows:

- one doctor per 1600 persons;
- one nurse per 600 persons;
- one health visitor per 5000 persons;
- one midwife per 100 births;
- one pharmacist per 3 doctors;
- one dentist per 4000 persons;
- one hospital bed per 175 persons;
- one PHC per 10 to 20 thousand population depending on population density and geographical area covered; and
- 15per cent of total government expenditure to be committed to health care, which at that time was about 2per cent of GDP.

The first response from the government and policy makers to the question of using the above norms in India is that they are excessive for a poor country and we do not have the resources to create such a

[10] These services need not be part of the health department or the national health authority that may be created and may continue to be part of the urban and rural development departments as presently.

level of health care provision. Such a reaction is invariably not a studied one and needs to be corrected.

Let us construct a selected epidemiological profile of the country based on whatever proximate data is available through official statistics and research studies. We have obtained the following profile after reviewing available information:

- Daily morbidity; 2per cent to 3per cent of population, that is about 20-30 million patients to be handled everyday (7 - 10 billion per year).
- Hospitalisation Rate: 20 per 1000 population per year with 12 days average stay per case, that is a requirement of 228 million bed-days (that is 20 million hospitalisations as per NSS -1987 survey, an underestimate because smaller studies give estimates of 50/1000/year or 50 million hospitalisations).
- Prevalence of Tuberculosis: 11.4 per 1000 population or a caseload of over 11 million patients.
- Prevalence of Leprosy: 4.5 per 1000 population or a caseload of over 4 million patients
- Incidence of Malaria: 2.6 per 1000 population yearly or 2.6 million new cases each year
- Diarrhoeal diseases (under 5): 7.5per cent (2-week incidence) or 1.8 episodes/child/ year or about 250 million cases annually.
- ARI (under 5): 18.4per cent (2-week incidence) or 3.5 episodes per child per year or nearly 500 million cases per year.
- Cancers:1.5 per 1000 population per year (incidence) or 1.5 million new cases every year.
- Blindness; 1.4per cent of population or 14 million blind persons.
- Pregnancies: 21.4per cent of childbearing age-group women at any point of time or over 40 million pregnant women.
- Deliveries/Births = 25 per 1000 population per year or about 68,500 births every day

(estimated from CBHI, WHO, 1988, ICMR,1990, NICD,1988, Gupta et.al.,1992, NSS,1987).

The above is a very select profile that reflects what is expected of a health care delivery system. Let us take handling of daily morbidity alone, that is, outpatient care. There are 30 million cases to be tackled every day. Assuming that all will seek care (this usually happens when health care is universally available, in fact the latter increases perception of morbidity) and that each GP can handle about 60 patients in a days work, we would need over 500,000 GPs equitably distributed across the country. This is only an average; the actual requirement will depend on spatial factors (density and distance). This means one GP per about 2500 population, this ratio being three times less favourable than what prevails presently in the developed capitalist and the socialist countries. Today we already have over 1,400,000 doctors of all systems (660,000 allopathic) and if we can integrate all the systems through a CME program and redistribute doctors as per standard requirements we can provide GP services in the ratio of one GP per less than 1000 population.

The neglect of the public health system is an issue larger than government policy making. The latter is the function of the overall political economy. Only a well-developed welfare state can meet the basic needs of its population. Given the backwardness of India the demand of public resources for the productive sectors of the economy is more urgent (from the business perspective) than the social sectors, hence the latter get only a residual attention by the state. The policy route to comprehensive and universal healthcare has failed miserably. It is now time to change gears towards a rights-based approach. The opportunity exists in the form of constitutional provisions and discourse, international laws to which India is a party, and the potential of mobilizing civil society and creating a socio-political consensus on right to healthcare. All these have to be bundled into a comprehensive health and healthcare legislation which is able to encompass all the issues and concerns discussed above.

Legal Route

Global experience clearly shows that countries that have established universal access to healthcare have been able to do it with comprehensive legislation that has organized the healthcare system under a common umbrella and pooled resources to deliver structured and regulated health services to its citizens. Legislation covers all dimensions of health and healthcare so that the issues and concerns highlighted above like access, provision of adequate infrastructure, discrimination, negligence, malpractices, quackery, healthcare systems, quality standards, occupational and environment health problems, reproductive health issues, violation of rights, allocation of resources, professional conduct, rights of patients, and protection against epidemics etc. can be taken care of. All the existing laws have been formulated in response to a specific situation or an issue. There has never been an attempt to legislate a comprehensive law covering the major aspects of health and healthcare. The latter can only emerge from a comprehensive health policy. Historically India had two opportunities, one in the Bhore Committee Report on the eve of Independence, and the second post Alma Ata when the 1982 National Health policy was formulated. Both these opportunities to translate the policy into law were lost because the approach to health and healthcare was a programme based one and not a comprehensive approach to establish universal and non-discriminatory access to healthcare.

Thus as yet in India there is no comprehensive legislation on health and healthcare. We have laws that cover selective aspects of health and healthcare that often these violate the principles of universality and non-discrimination. So we have social security laws that protect health interests of a selected class of the workforce, like the Factories Act, the ESIS Act and Maternity Benefit Act; laws to deal with healthcare establishments like the Hospital and Clinical Establishment Registration Acts of different states; laws to deal with epidemics like the Epidemic Diseases Act, the Notifiable Disease Act and the various state Public Health Acts; laws to prevent quackery, professional misconduct and malpractice like the Medical Council of India Act, the Organ Transplantation Act; laws to assure quality like the Drugs and Cosmetics Act and the Prevention of Food Adulteration Act, the Blood Banks Act; laws to deal with negligence like COPRA, the MTP Act for abortion, the PCPNDT Act to prevent sex-selective discrimination; laws for environment health like the Prevention of Pollution Act, the Biological Diversity Act, the Hazardous Substances Act, laws for occupational health like the Workmen's Compensation Act, etc.

The problem with the existing legislation is that it is piecemeal and addresses its objectives without contextualizing them in the overall context of the human right to health. They suffice to deal with specific situations or for specific persons but they don't have a generic applicability.

Indeed this review of cases under these various legislations has illustrated well the inadequacies of these laws from the perspective of rights.

In the interim these laws have served a limited purpose and guaranteed protection when violations take place. However, they do not provide a general right to health and healthcare and for the latter to happen all these laws have to be brought under the umbrella of an apex law which mandates the right to health and healthcare. This apex law must be contextualized within the framework of the ICESCR and other international covenants as well as the provision of the directive principles of the Indian Constitution and must facilitate the organization of the healthcare system into a regulated system which is under a public authority and financed by pooling all resources available in the country. To support this legislation a constitutional amendment to establish right to health and healthcare must also be put in place.

Comprehensive health legislation becomes an important tool for implementation of health policy and provides the managerial and administrative basis for the development of health systems. It is this latter element that is missing in India due to lack of comprehensive health legislation.

What should then comprehensive health legislation include? There are two aspects that health legislation has to cover. One is mandating that health care is a right and a specified mix of

health services will be assured as per the core content we have discussed earlier. The second aspect pertains to regulation of the larger healthcare system which includes private provision of various health and related services. The first one is the political commitment which translates policy into action and the second is the functional details of how the system will be controlled and made accountable. We have already discussed the first aspect earlier. Health legislation will have to also work out the organizational and financing framework for the entire healthcare system. [11] Both public and private healthcare has to be factored into the universal access healthcare system and all finances have to be pooled into a common kitty which is administered and controlled by a multi-stakeholder public authority. The Canada Health Act which mandates public spending for physician and hospital services is a good example.[12].

The regulatory dimension is the second aspect of healthcare legislation and this as we have seen earlier exists in a piecemeal way. Many of these specific laws would need to be brought in line with the apex legislation and strengthened accordingly. We will attempt here to define the regulatory principles for some critical areas where regulation has to be established and/or strengthened. The following suggestions on regulation encompass the entire health sector. However, they are not an exhaustive list but only some major important areas needing regulation or where it exists strengthening it.

1. Nursing Homes and Hospitals:

- Setting up minimum decent standards and requirements for each type of unit; general specifications for general hospitals and nursing homes and special requirements for specialist care, example maternity homes, cardiac units, intensive care units etc. This should include physical standards of space requirements and hygiene, equipment requirements, human power requirements (adequate nurse: doctor and doctor: beds ratios) and their proper qualifications etc.
- Maintenance of proper medical and other records, which should be made available statutorily to patients and on demand to inspecting authorities.
- Setting up of a strict referral system for hospitalisation and secondary and tertiary care
- Fixing reasonable and standard hospital, professional and service charges.
- Filing of minimum data returns to the appropriate authorities for example data on notifiable diseases, detailed death and birth records, patient and treatment data, financial returns etc.
- Regular medical and prescription audits which must be reported to the appropriate authority
- Regular inspection of the facility by the appropriate authority with stringent provisions for flouting norms and requirements
- Periodical renewal of registration after a thorough audit of the facility

2. Physicians and other medical practitioners:

- Ensuring that only properly qualified persons set up practice
- Compulsory maintenance of patient records, including prescriptions, with regular audit by concerned authorities
- Fixing of standard reasonable charges for fees and services
- Regulating a proper geographical distribution
- Filing appropriate data returns about patients and their treatment

---

[11] For a framework to operationalise this see Duggal, 2004

[12] There are five main principles in the Canada Health Act: **1. Public Administration:** All administration of provincial health insurance must be carried out by a public authority on a non-profit basis. They also must be accountable to the province or territory, and their records and accounts are subject to audits. **2. Comprehensiveness:** All necessary health services, including hospitals, physicians and surgical dentists, must be insured. **3. Universality:** All insured residents are entitled to the same level of health care. **4. Portability:** A resident that moves to a different province or territory is still entitled to coverage from their home province during a minimum waiting period. This also applies to residents who leave the country. **5. Accessibility:** All insured persons have reasonable access to health care facilities. In addition, all physicians, hospitals, etc, must be provided reasonable compensation for the services they provide. (http://laws.justice.gc.ca/en/C-6/233402.html; accessed on March, 30th 2006)

- Provision for continuing medical education on a periodic basis with licence renewal dependent on its completion

3. Diagnostic Facilities:

- Ensuring quality standards and qualified personnel
- Standard reasonable charges for various diagnostic tests and procedures
- Audit of tests and procedures to check their unnecessary use
- Proper geographical distribution to prevent over concentration in certain areas

4. Pharmaceutical industry and pharmacies:

- Allowing manufacture of only essential and rational drugs
- Regulation of this industry must be switched to the Health Ministry from the Chemicals Ministry
- Formulation of a National Formulary of generic drugs which must be used for prescribing by doctors and hospitals
- Ensuring that pharmacies are run by pharmacists through regular inspection by the authorities
- Pharmacies should accept only generic drug prescriptions and must retain a copy of the prescription for audit purposes

5. Health insurance and third party administration:

- Health insurance should be allowed only as a not-for-profit sector
- National and social insurance must be under public authority
- Premiums must be negotiated through a multi-stakeholder mechanism
- Insurance coverage must be comprehensive
- Insurance companies must directly settle claims with hospitals and physicians
- Insurance data must be in public domain
- Individual based exclusions should not be permitted
- Insurance must also cover preventive and promotive healthcare, maternity, dentistry and ophthalmic services

Many of these are covered in laws that already exist but they need to be linked and brought in line with the apex legislation which will be formulated within the rights perspective. And finally regulation has very little meaning if there is no audit agency to monitor what is happening.

To conclude, if we want to establish right to healthcare then we have to transcend the policy route and translate it into a legal route within the human rights framework. This is the only way to assure political commitment for right to health and healthcare.

References:

1. Abel-Smith, Brian (1977): Minimum Adequate Levels of Personal Health Care, in Issues in Health Care Policy, ed.John Mckinlay, A Milbank Reader 3, New York
2. Chapman, Audrey (1993): Exploring a Human Rights Approach to Healthcare Reform, American Association for the Advancement of Science, Washington DC
3. Duggal, Ravi (2002): Resource Generation Without Planned Allocation, Economic and Political Weekly, Jan 5, 2002
4. Duggal Ravi (2004): Operationalizing Right to Healthcare in India, ICFAI Journal of Healthcare Law, August 2004, Vol2, No. 3, pgs 13-42
5. OECD (1990): Health Systems in Transition, Organisation for Economic Cooperation and Development, Paris
6. Toebes, Brigit (1998): The Right to Health as a Human Right in International Law, Intersentia – Hart, Antwerp
7. WHO (1993): Third Monitoring of Progress, Common Framework, CFM3, Implementation of Strategies for Health for All by the Year 2000, WHO, Geneva,

Annexure 1

Cited Cases

Chapter 2: Fundamental Right to Health and Public Health Care

- Municipal Council, Ratlam v/s Vardhichand & Ors 1980 Cri LJ 1075
- C.E.S.C. Ltd. v/s Subhash Chandra Bose AIR 1992 SC 573
- Mahendra Pratap v/s Orissa State AIR 1997 Ori 37
- CERC Vs. Union of India 1995 3 SCC 42
- State of Punjab v/s Mohinder Singh Chawla 1997 2 SCC 83
- T. Ramakrishna Rao v/s Hyderabad Urban Development Authority
- S.K Garg v/s State of U.P decided on 21/12/1998
- Banga Khet Mzdoor Samiti v/s State of West Bengal (1996) 4 SCC 37
- Peoples' Union of Civil Liberties v/s Union of India
- State of Tripura v/s Amrita Bala Sen 2005 1 GLR 7
- Marri Yadamma v/s State of Andhra Pradesh AIR 2002 AP 164
- Noorunissa Begum v/s District Collector, Khammam AP HC dt. 27/6/2001
- Surjeet Singh v/s State of Punjab (1996) 2 SCC 336
- Devindar Singh Shergil v/s State of Punjab (1998) 8 SCC 552
- State of Punjab v/s Ram Lubhaya Bagga (1998) 4 SCC 117
- K.P. Singh v/s Union of India (2001) 10 SCC 167
- Kamlesh Sharma v/s Municipal Corporation of Delhi
- Ram Datt Sharma v/s State of Rajasthan AIR 2005 RAJ 317
- Dr Sarosh Mehta v/s General Manager, Central Railways
- Directorate of Enforcement v/s Ashok Kumar Jain (1998) 2 SCC 105
- D.K. Basu v/s State of West Bengal AIR 1997 SC 610

Chapter 3: Right to Emergency Health Care

- Dr Laxman Balkrishna Joshi v/s Dr. Trimbak Bapu Godbole AIR 1969 SC 128
- Paschim Banga Khet Mazdoor Samiti v/s State of West Bengal (1996)4 SCC 37
- Labonya Moyee Chandra v/s State of West Bengal SC decided on 31/7/1998
- Parmanand Katara v/s Union of India AIR 1989 SC 2039
- Supreme Court Legal Aid Committee v/s State of Bihar (1991) 3 SCC 482
- Poonam Sharma v/s Union of India AIR 2003 Delhi 50
- Parvat Kumar Mukherjee v/s Ruby General Hospital – Original Petition No. 90 of 2002 decided by the National Commission on 25.4.2005

Chapter 4: HIV / AIDS and Law

- Lucy D' Souza v/s State of Goa AIR 90 BOM 355
- Common Cause v/s Union of India AIR 1996 SC 929
- Subodh Srama and Anr v/s State of Assam decided on 26/9/2000

- MX of Bombay Indian Inhabitant v/s M/s. ZY AIR 1997 BOM 406
- M. Vijaya v/s The Chairman and Managing Director, Singareni Collieries Company Ltd 2002 ACJ 32
- Ex. Const. Badan Singh v/s Union of India and Anr 97 (2002) DLT 986
- Mr. X v/s Hospital Z AIR 2003 SC 664
- Dr. Tokugha Yepthomi v/s Appolo Hospital and Anr AIR 1999 SC 495
- Mr.X, Indian Inhabitant v/s Chairman, State level Police Recruitment Board 2006 (2) ALT 82
- P of Bombay v/s Union of India (2004) 136 STC 462 BOM
- Merind Ltd. v/s State of Maharashtra (2004) 136 STC 462 BOM
- Rao Saheb Mahadeo Gayekwad v/s Life Insurance Corporation of India and Anr. AIR 2004 KA 439

Chapter 5: Issues in Medical Practice

- Poonam Verma v/s Ashwin Patel (1996)4 SCC 332
- Dr. Mukhtiar Chand v/s State of Punjab (1998)7 SCC 579
- Subhashis Bakshi v/s W.B.Medical Council & Ors 2003 9 SCC 269
- Dr. Akhtar Hussain Delvi v/s State of Karnataka AIR 2003 Karnataka 388
- Basavaraj M. v/s Karnatak State Pharmacy Council AIR 2001 Karnataka 239
- Shivraj Singh v/s State of Uttaranchal AIR 2005 UTR 39
- Delhi Pradesh Registered Medical Practitioners v/s Director of Health, Delhi Admn. Services 1997 11 SCC 687
- State of Tamil Nadu v/s M.C. George W.A. No. 108 of 2005 and W.A.M.P. No. 153 of 2005
- Private Medical Practitioners Association of A.P. v/s State of Andhra Pradesh W.P. 15410 of 1995 decided by the AP High Court on 8.4.2002
- Electropathy Medicos of India v/s State of Maharashtra
- Uttar Pradesh v/s Electro Homeopathic Practitioners Association of India 2004 4 AWC 3148
- D.K.Joshi v/s State of U.P C.A. No. 2016 of 1996
- Charan Singh v/s State of U.P. AIR 2004 ALL 373
- Shri Sarjoo Prasad v/s State of Bihar 2003 1 BLJR 686
- M. Jeeva v/s R. Lalitha 1994 2 CPJ 73

Chapter 6: Medical Negligence

- Bolam v/s Friern Hospital Management Committee 1957 2 ALL ER 118
- Jacob Mathew v/s State of Punjab 2005 6 SCC 1
- Dr. Suresh Gupta v/s Govt. of Delhi (2004) 6 SCC 422
- Dr. Anand R. Nerkar v/s Smt Rahimbi Shaikh Madar 1991(1) Bom. C. R. p. 629
- Indian Medical Association v/s V.P. Shantha(1995) 6 SCC 651
- Charan Singh v/s Healing Touch Hospital (2000) 7 SCC 668
- Dr. J.J. Merchant v/s Shrinath Chaturvedi(2002) 6 SCC 635
- Spring Meadows Hospital v/s. Harjo Ahluwalia 1998 4 SCC 39
- Rajaram S.Parale v/s Dr. Kalpana Desai 1998 3 CPR 398 (BOM)
- Sailesh Munja v/s All India Institute of Medical Sciences (AIIMS) 2004 3 CPR 27 (NC)
- Ranjit Kumar Das v/s ESI Hospital 1998 1 CPR 165 (Cal)
- Suhas Haldulkar v/s Secretary, Public Health Dept., State of Maharashtra 1994 3 CPJ 89
- B.S. Hegde v/s Dr. Sudhanshu Bhattacharya 1992 CPJ 449
- Dr. Laxman Balkrishna Joshi v/s Dr. Trimbak Bapu Godbole AIR 1969 SC 128
- Philips India Ltd. v/s Kunju Punnu 1975 M. L.J. 792
- Poonam Verma v/s Ashwin Patel(1996) 4 SCC 332
- Shyam Sunder v/s State of Rajasthan AIR 74 SC 876

- Jasbir Kaur v/s State of Punjab AIR 1995 P&H 278
- Achutrao Haribhau v/s State of Maharashtra (1996) 2 SCC 63484
- Vinitha Ashok v/s Lakshmi Hospital (2001) 8 SCC 731
- S. Mittal v/s State of U.P 1989 3 SCC 223
- Eby Minor v/s GEM Hospital 2004 3 CPJ 37
- Dr. Kaligoundon v/s N. Thangamuthu 2004 3 CPJ 29 (NC)
- S.V. Panchori v/s Dr. Kaushal Pandey 1999 1 CPJ 332
- P.Venkatalaxmi v/s Dr. Y. Savitha Devi 2004 2 CPJ 14 (NC)
- T. Vani Devi v/s Tugutla Laxmi Reddy2003 1 CPJ 180
- Bhajan Lal Gupta v/s Mool Chand Kharati Ram Hospital 2001 1 CPR 70
- Dr. P.S. Hardia v/s Kedarnath Sethia 2004 3 CPJ 19 (NC)
- K.G.Krishnan v/s Praveen Kumar (minor) 2003 2 CPJ 125
- Savita Garg v/s Director, National Heart Institute 2004 8 SCC 56
- Mohd. Ishfaq v/s Dr. Martin D'souza 2002 2 CPR 151
- R.M. Joshi v/s Dr. P.B. Tahilramani 1993 3 CPR 435 (Bom)
- Uttaranchal Forest Hospital Trust v/s Smt. Raisan 2004 1 CPJ 257
- State of Punjab v/s Shiv Ram 2005 7 SCC 1
- Eyre v/s Measday 1986 1 ALL ER 488

Chapter 7: Drugs and Public Health

- Cadila Pharmaceuticals Ltd. v/s State of Kerala AIR 2002 Kerala 357
- Chimanlal v/s State of Maharashtra AIR 1963 SC 665
- Prabhudas Kalyanji Adhia v/s State of Maharashtra AIR 1970 BOM 134
- CCE v/s Richardson Hindustan Ltd. 2004 9 SCC 136
- Puma Ayurvedic Herbal (P) Ltd v/s CCE 2006 3 SCC 266
- S.R. Pvt. Ltd v/s Prem Gupta, Drug Controller (India) New Delhi AIR 1993 P&H 28
- Systopic Laboratories Pvt. Ltd. v/s Dr. Prem Gupta & Ors 1994 Supp 1 SCC 160
- Laxmikant v/s Union of India 1997 4 SCC 739
- Bharat Biotech International Ltd. v/s A.P. Health and Medical Housing and Infrastructure Development Corporation AP HC dt. 10/12/2002
- Sidi Pharmacy Pvt. Ltd. v/s Union of India 2004 (13) SCC 780
- AIDWA v/s Union of India 1998 5 SCC 214
- Vincent Panikurlangara v/s Union of India 1987 2 SCC 165
- Holy Cross Hospital v/s State of Kerala . High Court Order decided on 25/02/2002
- Kasim Bhai v/s State of UP AIR 1956 Allahabad 703
- Bharat Prasad Gupta v/s State of West Bengal 1995 SUPP 3 SCC 640
- Swantraj v/s. State of Maharashtra (1975) 3 SCC322
- Sagar Medical Hall v/s State of Bihar (CWJC) Patna HC dt. 7/12/01
- Hamdard Dawakhana v/s Union of India AIR 1960 SC 554
- State of Karnataka v/s R.M.K. Sivasubramanya Om 1978 CRI.L.J. 853 (Karnataka HC)
- Dr. Yash Pal Sahi v/s Delhi Administration (1963) 5 SCR 582
- K.S.Saini v/s Union of India AIR 1967 P&H 322
- Zaffar Mohammad v/s State of West Bengal AIR 1976 SC 171
- Kantirani Jaynarayan Mangal v/s State of Maharashtra [1] 1982 MLJ 822
- Anand Mohan Chapparwal v/s State 1996 CR LJ 596
- Novartis Case, the matter of an application for patent No. 1602/MAS/98 filed on July 17, 1998. Order of the Controller of Patents dated 25th January, 2006

Chapter 8: Right Of Workers To Health ,Occupational Health And Safety

- Consumer Education & Research Centre v/s Union of India AIR 1995 SC 922
- Rajangam, Secretary, Dist. Beedi Worker's Union v/s State of Tamil Nadu AIR 1993 SC 401
- Bandhua Mukti Morcha v/s Union of India AIR 1997 SC 2218
- MC Mehta v/s State of Tamil Nadu (1991) 1 SCC 283
- Asiad construction workers case - People's Union for democratic rights v/s union of India (1982)2 SCC 235
- Mangesh Salodkar v/s Monsanto Chemicals of India Ltd. Writ Petition No. 2820 of 2003 decided by the Bombay High Court on 13 th July, 2006

Chapter 9: Environment and Health

- Municipal Council Ratlam v/s Vardichandand Others AIR 1980 Supreme Court 1622
- Citizens Action Committee, Nagpur v/s Civil Surgeon, Mayo (General) Hospital, Nagpur and Ors AIR 1986 Bom 136
- Hamid v/s State of M.P AIR 1997 MP 191
- Kamlavati v/s Kotwal and others 2000
- Murli S Deora v/s Union of India AIR 2002 SC 40

Chapter 10: Mental Health Care

- Dr. Upendra Baxi v/s State of Uttar Pradesh 1983 2 SCC 308
- Rakesh Chandra Nararyan v/s State of Bihar 1989 SUPP 1 SCC 644
- Sheela Barse v/s. Union of India 1986 3 SCC 632
- Chandan Kumar Banik v/s State of West Bengal 1995 Supp. 4 SCC 505
- Re v/s Union of India (2002) 3 SCC 31
- In Saarthak Registered Society and another v/s Union of India (2002) 3 SCC 31
- Veena Sethi v/s State of Bihar W P (Cri) No 73 of 1982
- S P Sathe v/s State of Maharshtra W P No 1537 of 1984, Bombay
- Shukri v/s State of Maharashtra Writ Petition 357/98 delivered on October 14, 1998.
- B.R Kapoor v/s Union of India WP (Cri) No 1777-1778 of 1983

Chapter 11: Reproductive Rights

- Javed v/s State of Haryana and ors AIR 2003 SC 3057
- Haryana v/s Smt. Santara AIR 2000 SC 1888
- State of Punjab v/s Shiv Ram and Ors AIR 2005 SC 3280
- State of M.P. v/s Smt Sundari Bai and Anr AIR 2003 MP 284
- Achutrao Haribhau Khodwa v/s State of Maharashtra And Ors (2004) 3 CAL LT 609 (HC)
- Murari Mohan Koley v/s The state and Anr (2004)3 CAL LT 609(HC)
- Arun Balakrishnan Iyer and Anr v/s Soni Hospital and Ors AIR 2003 Mad 389
- Ms.X v/s Mr. Z and Anr 96 (2002) DLT 354
- Cehat and ors. v/s Union of India AIR 2003 SC 3309
- Shakuntala Sharma v/s State of U.P 2000 Allahabad Law Journal 1550
- A.K. Reddy v/s Depot Manager, APSRTC 2000 Andhra Law Times 214
- Ramakant Rai & Health Watch UP and Bihar v/s Union of India W.P (C) No 209 of 2003
- Stree Shakti Sanghathana v/s Union of India WPC NO. 680 OF 1996 decided on August 24, 2000

Chapter 12: National Human Rights Commission

- Jolly George v/s Bank of Cochin AIR 1980 SC 470
- Vishakha v/s State of Rajasthan AIR 1997 SC 323; (1997) 6 SCC 241
- Jai Singh's Case CWP 10791/2002
- Charanjeet Singh's Case Crl W 729/2002 and 1278/2004, Decided On: 04.03.2005
- Babu Lal's Case NHRC Annual Report 2001-2002
- Janadhikar Case NHRC Annual Report 2003-2004
- Ramkumari : Case No.7122/24/98-99
- Mala Bharat Jadhav : Case NO. 2002/2002: Order dt. 4/4/03
- Siva Salian : Case No. 109/01 : Order dt.19/05/04
- BHEL : Case No. 109/01 : Order dt.19/05/04
- Starvation Death Case Writ petition (Civil) No.42/97.
- Indian Council Legal Aid Case : [1] Writ Petition (Civil) No. 42/97 filed before the Supreme Court of India on 23 December 1996
- Bihar Mental Asylum Case NHRC Order June 20, 2006
- Agra Mental Asylum Case NHRC Order July 5, 2004
- Homosexuality Case : Complaint No. 3920, filed on May 29, 2001

Chapter 13: Other Cases

- P. Rathinam v/s Union of India AIR 1994 SC 1844
- Smt. Gian Kaur v/s State of Punjab (1996) 2 SCC 648
- C.A. Thomas Master v/s Union of India 2000 CRLJ 3729
- Re T (Adult Refusal of Medical Treatment) Case 1992 4 ALL ER 649 affirmed in 2002 EWHC 429
- Re B (Adult Refusal of Medical Treatment) Case 2002 2 FCR 1
- Airedale National Health Service v/s. Bland 1993 AC 789
- Raghunath Raheja v/s Maharashtra Medical Council Writ Petition No. 3720 of 1991
- Seenath Beevi v/s State of Kerala 2003 3 KLT 788
- C.L. Venkata Rao v/s Govt. Of Andhra Pradesh 2005 6 ALD 327
- Santosh Hospitals Pvt. Ltd. v/s State Human Rights Commission AIR 2005 MAD 348
- Balbir Singh v/s Authorisation Committee AIR 2004 DEL 413
- S. Malligamma v/s State of Karnataka ILR 2005 KAR 1557
- Ramamurthy v/s State of Karnataka (1997) 2 SCC 642
- Tapas Kumar Bhanja v/s State of West Bengal and Anr(2006) 2 CALLT 108(HC)
- R D Upadhyaya v/s State of AP 2006 (4) scale 336

Annexure 2

Legal Glossary

Affidavit
A written and signed statement sworn in front of a Court officer a written statement that is signed and sworn on oath and therefore able to be used as evidence in court.

Allegation
A Statement of the issues in a written document (pleading) which a person is prepared to prove in court

Amend
To alter formally by modification, deletion, or addition

Appeal
A request made after a trial, asking another court (usually the higher court) to decide whether the trial was conducted properly. To make such a request is "to appeal" or "to take an appeal." One who appeals is called the appellant.

Bail
The money or bond put up to secure the release of a person who has been charged with a crime.

Case Law
Legally binding and commonly accepted rules or principles developed over time through the gradual accumulation of rulings by judges. Law made by court cases rather than legislation

Caveat
A notice given to a legal authority not to do something until the person giving notice can be heard.

Constructive notice
The law presumes that everyone has knowledge of a fact when the fact is a matter of public record.

Contempt
Failure to follow a court order. One side can request that the court determine that the other side is in contempt and punish him or her

Costs
Allowance for expenses in prosecuting or defending a suit. Ordinarily this does not include attorney fees

Court order
A legal decision made by a court that commands or directs that something be done or not done. It can be made by a judge, commissioner or magistrate.

Custody
The legal right given to a person of official authority to exercise complete and immediate control over a person to insure appearance in court. Custody also refers to the actual imprisonment of the accused after a criminal conviction

Damages
A sum of money paid in compensation for loss or injury

Defamation
Defamation is an injury to a person's character or reputation such that a right thinking person would think less of the injured person as a result of the injurious act.

Default Judgement
A court decision in favour of the plaintiff when the defendant doesn't answer or go to court when they're supposed to

Defendant
In a civil suit, the person complained against; in a criminal case, the person accused of the crime.

Ex parte
On behalf of only one party, without notice to any other party. For example, a request for a search warrant is an ex parte proceeding, since the person subject to the search is not notified of the proceeding and is not present at the hearing.

Habeus Corpus
Legal term for the right to petition a court to decide whether confinement has been undertaken with due process of law

Immunity
Legal protection from liability. There are many categories of immunity in civil and criminal law. For example, sovereign immunity protects government agencies from civil liability and judicial immunity protects judges acting in their official capacities.

Implied consent
A consent that is drawn from the facts of the surrounding circumstances

Indigent
Needy, poor, impoverished. A defendant who can demonstrate his or her indigence to the court may be assigned a court-appointed attorney at public expense

Injunction
A court order that prohibits a party from doing something (restrictive injunction) or compels them to do something (mandatory injunction).

Interrogatories
Written questions sent by one side in a lawsuit to an opposing side as part of pre-trial discovery in civil cases. The side that receives the interrogatories must answer them in writing under oath.

Judicial review
A procedure where the court can review administrative decisions of government

Jurisdiction
The authority, capacity, power or right of a court to hear and decide a legal matter

Natural Justice
Rules and procedure to be followed by, among others, departments when deciding rights of others or adjudicating disputes. The rules are: to act fairly, and in good faith; to act without bias (not prejudicing nor to be personally interested in the matter); and to afford a fair hearing. "Justice must not only be done, but be seen to be done

Negligence
Failure to use that degree of care which an ordinary person of reasonable prudence would use under the given or similar circumstances. A person may be negligent by acts of omission or commission or both.

Notice
Written warning to another of a person's intention to do something or take some (legal) action.

Plaintiff
A person who initiates a case in court. That person may also be referred to as the Claimant, Petitioner or Applicant. The person who is being sued is generally called the Defendant or Respondent

Pleadings
Written statements delivered by parties to one another setting out the legal and factual basis of a claim or defence. Pleadings may include a statement of claim, defence and reply

Power of Attorney
A legal document that authorizes another person to act on one's behalf. A power of attorney can grant complete authority or can be limited to certain acts and/or certain periods of time.

Precedent
A precedent is a previous decision used as a justification for deciding a subsequent case in the same way.

Prejudice
Bias for or against someone or something that fails to take true account of their characteristics

Probate
Probate is the legal process of proving a will, appointing an executor, and settling an estate; but by custom, it has come to be understood as the legal process whereby a deceased person's estate is administered and distributed.

Prosecutor
A lawyer representing the government in a criminal case

Public Interest
There is some kind of general interest of the community as a whole which can be affected by the actions of governments or private agents.

Quash
To annul or set aside. In law, a motion to quash asks the judge for an order setting aside or nullifying an action, such as "quashing" service of a summons when the wrong person was served.

Reasonable doubt
An accused person is entitled to acquittal if, in the minds of the judge, guilt has not been proven beyond a "reasonable doubt"; that state of mind of judges in which they cannot say they feel an abiding conviction as to the truth of the charge.

Receiver
Receiver is the person appointed by the court or a creditor to administer the financial and business affairs of a debtor, typically one who is bankrupt or insolvent

Relief
Redress awarded by a court as a compensation for past injury.

Res ipsa Loquitur
Res ipsa loquitur is a legal term from the Latin meaning literally, "The thing itself speaks" but is more often translated "The thing speaks for itself". The doctrine is applied to tort claims which, as a matter of law, do not have to be explained beyond the obvious facts. It is most useful to plaintiffs in certain negligence cases.

Repudiation
Refusal to acknowledge or pay a debt or honour a contract (especially by public authorities); "the repudiation of the debt by the city.

Review
A judicial re-examination of the proceedings of a court.

Rule
A rule of procedure that a Court must follow, related to a specific Act. Rules are made by a lawful judiciary authority

Service
Giving court papers to the other party by hand delivering, sending them by registered mail or notifying the other party of the dissolution case through publication of a notice in a newspaper.

Statutory
Prescribed or authorized by or punishable under a statute; "statutory restrictions"; "a statutory age limit"; "statutory crimes".

Statutory declaration
A written statement of facts that the person making it signs and solemnly declares to be true.

Stay
A judicial order forbidding some action until an event occurs or the order is lifted.

Summary Judgement
A finding and entry of judgment by the court after a hearing and review of the claims and the evidence of the parties prior to a trial wherein the court determines that there is no genuine issue or dispute as to any material fact available for presentation and that the evidence, as a matter of law, is insufficient to allow such claim to continue and renders judgment in favour of one party

Third Party
A party that is not a signatory to an agreement but who may nevertheless have rights and obligations relating to that agreement.

Trial
A proceeding or hearing of evidence in a court having jurisdiction over the persons, entities, and subject matter for a determination of all issues between the parties based upon the applicable substantive law.

Tribunal
A special court outside the civil and criminal judicial system that examines special problems and makes judgements, e.g. an industrial tribunal, which resolves disputes between employers and employees.

Undertaking
A promise, reduced to writing, which is legally enforceable.

Warrant
A written order directing the arrest of a party. A search warrant orders that a specific location be searched for items, which if found, can be used in court as evidence.

Without prejudice
Without prejudice" is used in legal negotiations (eg for a motor vehicle accident, an offer can be made to pay without admitting fault for the accident). If the negotiations fail, a person will not be prejudiced or compromised by concessions or offers made in negotiations.

Witness
A person called upon by either side in a lawsuit to give testimony before the court.

Abbreviations

- AIR - All India Reporter
- ALD - Andhra Law Digest
- ALJ - Allahabad Law Journal
- ALT - Andhra Law Times
- ALL ER - All England Law Report
- AWC - Allahabad Weekly Cases
- BLJR - Bihar Law Judicial Reviews
- CAL LT - Calcutta Law Times
- CPJ - Consumer Protection Journal
- CPR - Consumer Protection Reporter
- CR - Consumer Reports
- Cri LJ - Criminal Law Journal
- CWJC - Civil Writ Judicature Court
- DLT - Delhi Law Times
- EWHC - England and Wales High Court
- FCR - Federal Court Reporter
- GLR - Guwahati Law Review
- HC - High Court
- KLT - Kerala Law Times
- ML J - Maharashtra Law Journal
- STC - Sales Tax Cases
- SC - Supreme Court
- SCR - Supreme Court Report
- SCC - Supreme Court Cases
- WA - Writ Application

Annexure 3

Health Legislations

Main Title	SUB TITLE	Central / State Central
Pre-Natal Diagnostic Techniques (Regulation & Prevention Of Misuse) Amendment Act, 2002 http://mohfw.nic.in/titlepage.htm	Pre-Natal Diagnostic Techniques (Regulation & Prevention Of Misuse) Amendment Act, 2002	Central
Medical Termination of pregnancy Amendment Act, 2002 http://mohfw.nic.in/MTP.htm	Medical Termination of Pregnancy (Amendment) Act, 2002.	Central
The Maternity Benefit Act, 1961 http://www.vakilno1.com/bareacts/maternitybenact/maternitybenact.htm	Amended by the Maternity Benefit (Amendment) ACT, 1955 & Maternity Benefit Rules, 1963	Central
Bureau Of Indian Standards Act,1986 http://www.bis.org.in/bs/bisact.htm	With Bureau of Indian Standard Rules,1987	Central
Homeopathy (Minimum Standards of Education Regulations, 1983) http://202.54.104.236/intranet/eip/legislation/article_list.php?cid=16&scid=38		Central
Homoeopathy (Degree Course B.H.M.S. Regulations, 1983) http://202.54.104.236/intranet/eip/legislation/article_list.php?cid=16&scid=38		Central
Homoeopathy (Diploma Course) Regulations, 1983 http://202.54.104.236/intranet/eip/legislation/article_list.php?cid=16&scid=38		Central
The Environment (Protection) Act, 1986 (Bare Act) http://envfor.nic.in/legis/env/env1.html	29 of 1986	Central
The Transplantation Of Human Organs Act 1994 (Bare Act) http://www.mohanfoundation.org/inos/tho/thobill1.asp		Central
The Transplantation of Human Organ (Amendment) Rule 2002	ACT NO 42 OF 1994 With Transplantation of Human Organs 1994	Central

Main Title	SUB TITLE	Central / State Central
The Indian Medical Council (Amendment) Act, 2001 http://video.disc.iisc.ernet.in/vigyan/imcact.html	The Medical Council of India Regulation, 2000	Central
The Indian Medicine Central Council (Amendment) Act 2002 http://www.amam-ayurveda.org/notification.htm		Central
The Indian Medical Degrees Act, 1916 http://202.54.104.236/intranet/eip/legislation/article_list.php?cid=16&scid=38		Central
Indian Nursing Council Act, 1947 http://202.54.104.236/intranet/eip/legislation/article_list.php?cid=16&scid=38		Central
Consumer Protection Act (1986) http://www.vakilno1.com/bareacts/consumerprotectionact/consumerprotectionact.htm		Central
The Epidemic Diseases Act 1897 http://www.commonlii.org/in/legis/num_act/eda1897150/		Central
The Coroners'act 1871 http://www.commonlii.org/in/legis/num_act/ca1871120/		Central
The Indian Medical Degree Act, 1916 http://www.commonlii.org/in/legis/num_act/imda1916162/	Maharashtra act no. XLVI of 1963 (as modified up to 25th july 1989)	Maharshtra
The Bombay Nursing home Registration Amendment Act 2005 http://maha-arogya.gov.in/actsrules/nursing/BombayNursingHome.pdf		Maharashtra
Maharastra Medical Council Amendment Act,2003 http://www.mmcmumbai.com/Notice.htm		Maharashtra
The Maharashtra Nursing Council By Laws 1973	(Modified up to 31st May 1993)	Maharashtra
The Indian Medical Degrees (Maharashtra Extension & Provision For University) Act 1961		Maharashtra
Maharashtra Council Of Indian Medicine Rules, 1961		Maharashtra
Maharashtra Council Of Indian Medicine (Election) Rules 1907		Maharashtra
Maharashtra Board & Faculty Of Ayurvedic & Unani Systems Of Medicine	(Conditions of service at registrar & staff) Rules, 1968	Maharashtra
Court Of Examiners Of Homeopathic & Biochemic Systems Of Medicine, - Bombay		Maharashtra
The Maharashtra Kidney Transplantation Act 1982		Bombay
The Bombay Medical Act (Bare Act), 1912	Bombay ACT No VI of 1912	Bombay

Main Title	SUB TITLE	Central / State Central
A) The Bombay Medical (Amendment) Act, 1916 (Bare Act)	BOMBAY ACT No IV of 1916	Bombay
B) The Bombay Medical (Amendment) Act, 1918 (Bare Act)	BOMBAY ACT NO. III OF 1918	Bombay
Rules & Regulations Of The Bombay Medical Council 1913		Bombay
Bombay Anatomy Act, 1949		Bombay
Bombay Anatomy Rules 1950		Bombay
The Bombay Public Trusts Act,1950		Bombay
The Rules & Regulations Of The Madras Medical Council 1914		Madras
The By Laws Of The Madras Medical Council1914		Madras
The Bengal Medical Act 1914 (Bare Act)	BENGAL ACT NO. IV OF 1914	Bengal
The West Bengal Clinical Establishments Act, 1950 http://www.wbhealth.gov.in/download/The%20West%20Bengal%20Clinical%20Establishment%20Rules,%201951,%20as%20Modified%20up%20to%2031st%20January,%202001.pdf	West Bengal Act LVI of 1950 (modified up to 1st march 1995)	West Bengal
The Dentist (Amendment) Act 1993 http://202.54.104.236/intranet/eip/legislation/article_list.php?cid=16&scid=38		Central
The Homeopathy Central Council Act, 1973 http://202.54.104.236/intranet/eip/legislation/article_list.php?cid=16&scid=38		Central
Homeopathy (Minimum Standards of Education) Regulations 1983 http://202.54.104.236/intranet/eip/legislation/article_list.php?cid=16&scid=38	Under Homeopathy Central Council Act 1973	Central
The Registration of Births & Deaths Act 1969 http://des.delhigovt.nic.in/Vital/ACT.pdf		Central
Bombay Homeopathic Practitioners Act, 1959 (Bare Act)	Bombay Act No. XII OF 1960 (As modified up to 28th July 1989)	Maharashtra
Bombay Medical Practitioners Act, 1938, (Bare Act)	Bombay Act No. XXVI OF 1938, (Indian Systems)	Maharashtra
The Maharashtra Medical Practitioners Act, 1961 (Bare Act)	Maharashtra Act No XXVIII of 1961 (for Ayur/Sitthal/ unani – modified up to 31st Oct. 1985	Maharashtra
The Bombay Nurses, Midwives & Health Visitors Act, 1984	ACT NO XIV OF 1994 (modified up to 1962)	Maharashtra

Main Title	SUB TITLE	Central / State Central
The Maharashtra Nurses Act, 1966 (Bare Act)	Maharashtra Act No. XL of 1966	Maharashtra
The Maharashtra Nurses (Preparation Of List) Rules 1970		Maharashtra
The Bombay Nurses, Midwives & Health Visitors Registration Act, 1935 (Bare Act)	Bombay Act No VII of 1935	Maharashtra
The Bombay Homeopathic Practitioners Act, 1959 (Bare Law)	Bombay Act No XII of 1960 (As modified up to 25th July 1989)	Maharashtra
Maharashtra Homeopathic & Biochemical Practitioners Rules 1961		Maharashtra
Maharashtra Dentists (Ethical Conduct) Rules, 1968		Maharashtra
The Maharashtra Medical Practitioners (Publication Of Medical List) Rules 1966		Maharashtra
The Maharashtra Medical Practitioners (Enquiry Into Misconduct) Rules 1969		Maharashtra
Bombay Dentists Rules, 1951		Bombay
The Madras Nurses & Midwives Bill	Bill No II of 1924	Tamilnadu
Andhra Pradesh Medical Practitioners (Amendment) Registration Act, 1986	Act No 28 of 1986	Andhra Pradesh
The National Institute of Pharmaceutical Education and Research Act, 1998		Central
The Bombay Dangerous Drugs Rules 1935		Bombay
The Drugs & Cosmetics Act 1940 (Bare Act) http://cdsco.nic.in/html/Copy%20of%201.%20D&CAct121.pdf	(23 OF 1940) As modified up to 1st June 1984	Central
The Pharmacy Act, 1948 http://202.54.104.236/intranet/eip/legislation/article_list.php?cid=16&scid=38		Central
The Medicinal & Toilet Preparations (Excise Duties) Act, 1955, (Bare Act) http://www.vakilno1.com/bareacts/medicaltoiletprepact/medicaltoiletprepact.htm	Act No. 60 OF 1955 With the Medicinal & Toilet Preparations Rules (Excise duties) Rules, 1986	Central
The Narcotic Drugs & Psychotropic Substances Act, 1985 http://www.unodc.org/unodc/en/legal_library/in/legal_library_1987-06-05_1985-33.html	(61 OF 1985)	Central
The Bombay Drugs (Control) Act, 1989 (Bare Act)	Bombay Act No XI of 1960	Maharashtra
The Drugs (Prices Control) Order, 1995 http://tnhealth.org/prices.doc	Under Section 3 of the Essential Commodities Act 1955 (CENTRAL)	Central

Main Title	SUB TITLE	Central / State Central
The Mental Health Act, 1987 (Bare Act) http://www.disabilityindia.org/mentalact.cfm	(Act No 14 of 1987) With The State Mental Health & Central Rules, 1990.	Central
The National Trust for Welfare of Persons with Autism. Cerebral Palsy, Mental Retardation, and Multiple Disabilities Act 1999. http://www.disabilityindia.org/trustact.cfm		Central
The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Mental Disabilities Rules, 2000 *	Under The National Trust for Welfare of Persons with Autism. Cerebral Palsy, Mental Retardation, and Multiple Disabilities Act 1999.	Central
The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 http://www.disabilityindia.org/pwdacts.cfm		Central
The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Rules, 1996 http://www.disabilityindia.org/pwdacts.cfm	Under The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Rules, 1996	Central
The Rehabilitation Council of India Act, 1992 http://www.disabilityindia.org/rciact.cfm		Central
Rehabilitation Council of India (conditions of the service of the member secretary, officers and other employees) Regulations 1998. *		Central
The Aircraft Act, 1934 http://dgca.nic.in/rules/act-ind.htm		Central
The Indian Aircraft (Public Health) Rules, 1954 (Amended in 1969) http://nihfw.org/ndc-nihfw/html/Legislations/IndianAirCraft.htm	Under the Aircraft Act, 1934	Central
Indian Port Health Rules, 1955 *		Central
The Hazardous Waste Management and Amendment Rules, 2002 http://envfor.nic.in/legis/hsm/so593e.htm	Under Environment Protection Act 1986	Central
The Air (Prevention and Control of Pollution) Act, 1981, as amended by AmendmentAct, 1987. http://envfor.nic.in/legis/legis.html#B	The Air (Prevention and Control of Pollution) Rules, 1982. The Air (Prevention and Control of Pollution) (Union Territories) Rules, 1983.	Central
The Bhopal Gas Leak Disaster (Processing of Claims) Amendment Act, 1992 *		Central

Main Title	SUB TITLE	Central / State Central
The Biological Diversity Act, 2002 http://72.14.235.104/search?q=cache:U8NHP_ePL-KcJ:www.rupfor.org/downloadq/Biological%2520Diversity%2520Act%252202002.pdf+The+Biological+Diversity+Act,+2002&hl=en&ct=clnk&cd=3&gl=in	Biological Diversity Rules, 2003	Central
Bio-Medical Waste (Management and Handling) Rules, 1998 http://dpcc.delhigovt.nic.in/act_bmw.htm	Under Environment Protection Act 1986	Central
The Water (Prevention and Control of Pollution) Cess (Amendment) Act 2003 http://envfor.nic.in/legis/water/wc_act_03.htm		Central
The Water (Prevention and Control of Pollution) Act, 1974 http://www.vakilno1.com/bareacts/waterprevcontact/waterprevact.htm	The Water (Prevention and Control of Pollution) Act, 1975	Central
The Insecticides (Amendment) Act, 2000 http://video.disc.iisc.ernet.in/vigyan/insect.htm	The Insecticides rules, 1993	Central
The Noise Pollution (Regulation and Control) Rules, 2000 http://dpcc.delhigovt.nic.in/act_noise.htm	Under Environment Protection Act 1986	Central
Ozone Depleting Substances (Regulation and control) Rules, 2000 http://envfor.nic.in/legis/ods/odsrcr.html#http://envfor.nic.in/legis/ods/odsrcr.html	Under The Environment Protection Act, 1986	Central
Consumer Protection (Amendment) Act, 2002 http://www.indiapost.gov.in/PSCIB/Resource_files/CPACT2002.mht		Central
Right to Information Act 2005 http://persmin.nic.in/RTI/WebActRTI.htm		Central
The Registration of Death and Births Act, 1969 http://des.delhigovt.nic.in/Vital/ACT.pdf		Central
Indian Red Cross Society Act 1920 * The Indian Institute of Medical Sciences Act, 1956*	Indian Red Cross Rules 1994	Central
The Private Medical Educational Institutions (Regulation of Admission and Fixation of Fee) Bill, 2005 http://mohfw.nic.in/Bill-third%20draft%20dt%2026.10.05.htm		Central
Indian Nursing Council Act, 1947 http://video.disc.iisc.ernet.in/vigyan/nursing.html		Central
The Food Safety and Standards Act, 2006 http://mohfw.nic.in/Food%20Safety%20Standard%20Act.pdf		Central
Prevention of Food Adulteration Act, 1954 http://mohfw.nic.in/pfa%20acts%20_and%20rules.pdf	Prevention of Food Adulteration (7th Amendment) Rules 2002	Central

Main Title	SUB TITLE	Central / State Central
Infant Milk Substitute, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Amendment Act 2003 *		Central
Essential Commodities Act, 1955 http://agri.mah.nic.in/agri/input/html/essen_comm_index.htm	Vegetable Oil Products (Regulation) Order, 1998	Central
Beedi Workers Welfare Fund Act, 1976 *		Central
The Factories Act, 1948 http://www.labour.delhigovt.nic.in/act/html_ifa/fa1948_index.html		Central
The Mines Act, 1952 http://www.geocities.com/minsafety/ma_1952.htm	Mines Creche Rules 1966	Central
Motor Transport Workers Act, 1961 http://www.infreight.com/motortransport_workers_act.asp		Central
Plantations Labour Act, 1951 http://nrcw.nic.in/shared/sublinkimages/19.htm		Central
Public Liability Insurance Act, 1991 http://envfor.nic.in/legis/public/public1.html	Public Liability Insurance Rule, 1991	Central
The Fatal Accidents Act, 1855 http://www.vakilno1.com/bareacts/fatalaccidentsact/fatalaccidentact.htm		Central
Workmen Compensation Act, 1923 http://www.vakilno1.com/bareacts/workmenscompensationact/workmenscompensationact.htm		Central
Contract Labour (Regulation and Abolition) Central Rules, 1971 http://labour.delhigovt.nic.in/act/details_acts/contractlabour/rules,%201971/part_8.html	Under Contract Labour (Regulation and abolition) Act 1970	Central
Safai Karamchari Act 1993 *		Central
The Personal Injuries (Compensation Insurance) Act 1963 http://gist.ap.nic.in/cgi-bin/gent/gentdescs.cgi/?bk=4&a=2&tb=injudesc&l1=1		Central
Dock Workers (Safety, health and welfare) Rules, 1987 http://dgfasli.nic.in/html/dockact/rule1.htm	Dock Workers (Safety, health and welfare) Act 1986	Central
Drugs Control Act, 1950 *		Central
Medicinal And Toilet Preparations (Excise Duties) Act, 1955 http://www.vakilno1.com/bareacts/medicaltoiletprepact/medicaltoiletprepact.htm		Central

Main Title	SUB TITLE	Central / State Central
Drugs (Price Control) Order, 1995 http://nppaindia.nic.in/drug_price95/txt1.html	Under Essential Commodities Act, 1955	Central
Manufacture, Storage and Import of Hazardous Chemical (Amendment) Rules, 2000 http://envfor.nic.in/legis/hsm/msihcar.html	Under Environment Protection Act, 1986	Central
Recycled Plastics Manufacture and Usage Rules 1999 http://72.14.235.104/search?q=cache:hu1Tz1FZ3HQJ:www.sanctuaryasia.com/resources/environlaw/recycledplasticsmanufacture.doc+Recycled+Plastics+Manufacture+and+Usage+Rules+1999&hl=en&ct=clnk&cd=1&gl=in	Under Environment Protection Act, 1986	Central
Cigarettes (Regulations of Production, Supply and Distribution) Act, 1975 http://202.53.96.14/statues/stat44.asp		Central
The Cigarettes and Other Tobacco Products (prohibition of Advertisement And Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003 *	The Cigarettes and Other Tobacco Products around Educational Institutions Rules 2004	Central
Maternity Benefit Act, 1961 http://www.vakilno1.com/bareacts/maternitybenact/maternitybenact.htm	Maternity Benefit (Mines and Circus) Rules, 1963	Central
Life Insurance Corporation Act, 1956 http://www.vakilno1.com/bareacts/licact/licact.htm		Central
The Life Insurance (Emergency Provisions) Act, 1956 *		Central

* Ref. Health Legislation in India by Sunil Nandraj and Anagha Khot, SAERO WHO, 2007 available at http://www.whoindia.org

Annexure 4

Important Court Websites

http://www.judis.nic.in/ - Judgments Information System - Providing information about Indian Judiciary, disposed & pending case status in Supreme Court and high courts and the judgement information system.

http://www.indiancourts.nic.in/ - Indian courts - Offers information about Indian judiciary, IT in judiciary, Ministry of Law and Justice, judgement information system, case status information and cause lists.

http://patnahighcourt.bih.nic.in/ - High Court of Patna - Providing information about its history, judges, case status, cause list, district courts, I.T. activities and judgements.

http://hcbom.mah.nic.in/ - High Court of Bombay - Official website of bombay high court providing information about chief justices, officers, court orders, proceedings and other legal services.

http://hcraj.nic.in/ - High Court of Rajasthan - official website of Rajasthan High Court with information about its history, CJs, judges, registrar, cause list and case status.

http://highcourt.chd.nic.in/newhcpage/default.htm -High Court of Punjab & Haryana Official site of High Court of Punjab and Haryana providing information about judges, cause list, cases and decisions.

http://karnatakajudiciary.kar.nic.in/ - High Court of Karnataka - Providing information about High Court judgements, sitting list, cause list, case status and sub-ordinate courts.

http://jkhighcourt.nic.in/ - High Court of Jammu & Kashmir - Engaged in taking decision for cases of Jammu & Kashmir providing information about CJs, registrars, judgements, pendency statistics, subordinate judiciary and year wise law report.

http://hcbombayatgoa.nic.in/ - Bombay High Court in Goa - Providing information about case status, orders, judgements, cause list and bombay court.

http://ghconline.nic.in/ - High Court of Assam, Nagaland, Meghalaya, Manipur, Tripura, Mizoram and Arunachal Pradesh - providing information about history, judgments, cause list, judges, statistics and district courts.

http://delhihighcourt.nic.in/ - Delhi High Court - Website of Delhi High Court providing information about CJ and sitting judges, registrars, court rules, nominated counsel, judgements, cause list, day to day orders and Delhi district courts.

http://cghighcourt.nic.in/ - High Court of Chhattisgarh - Engaged in taking decision for cases in Chhattisgarh and providing information about sitting judges, initial case statistics, daily cause list, office order and list of advocates to be registered.

http://supremecourtofindia.nic.in/ - Supreme Court of India - A website for getting information about the latest cases decided by the Supreme Court of India by date, name, subjects with online searchable database for finding any particular case, a list of latest cases with details and a lawyer directory.

http://www.jharkhandhighcourt.nic.in/ - High Court Jharkhand - Providing information about Jharkhand High Court's history, chief justices and judges and other information.

http://www.highcourtofkerala.nic.in/ - High Court of Kerala - High Court for the State of Kerala and also having jurisdiction over the union territory of Lakshadweep.

Annexure 5

Public Interest Litigation

Public Interest Litigation is not defined in any statute or act. It has been interpreted by judges to consider the *intent of public at large*. Although, the main and only focus of such litigation is only 'Public Interest' there are various areas where a Public Interest Litigation can be filed

Who can file:

Any public-spirited person can file a Public Interest Litigation case (PIL) on behalf of a group of persons, whose rights are affected. It is ***not necessary,*** that person filing a case should have a direct interest in this Public Interest Litigation. For example: A person in Mumbai can file a Public Interest Litigation for malnutrition deaths in Orissa. Someone can file a PIL in the Supreme Court for taking action against a cracker factory that's employing child labour. Any person can file a PIL on behalf of a group of affected people. However, it will depend on the ***facts of the case,*** whether it should be allowed or not.

The Supreme Court (SC), through its successive judgments has relaxed the strict rule of 'locus standi' applicable to private litigation.

A PIL can be filed when the following conditions are fulfilled:

- There must be a public injury and public wrong caused by the wrongful act or omission of the state or public authority.
- It is for the enforcement of basic human rights of weaker sections of the community who are downtrodden, ignorant and whose fundamental and constitutional rights have been infringed.
- It must not be frivolous litigation by persons having vested interests.

Against Whom :

A Public Interest Litigation can be filed ***only*** against a State / Central Government, Municipal Authorities, and ***not*** any private party. However a "Private party" can be included in the Public Interest Litigation as a "Respondent", after making the concerned State authority a party. For example, in the case of a private factory in Delhi, causing pollution, then people living in its vicinity or any other person can file a PIL against the Government of India, the State Pollution Board and also against the private factory.

However, a PIL ***cannot*** be filed against the private party alone; the concerned State Government, and State authority has to be made a party

Procedure in High Court:

A PIL is filed in a High court, and then two copies of the petition have to be filed. Also, an advance copy of the petition has to be served on the each respondent, i.e. opposite party, and this proof of service has to be affixed on the petition. In **Supreme Court:** If a PIL is filed in the Supreme Court, then ***(four + one) (i.e. five)*** sets of petition have to be filed. The opposite party is served the copy only when notice is issued

Court Fee:

A Court fee of Rs. 50, per Respondent (i.e. for each number of opposite party, court fees of Rs. 50) has to be affixed on the petition.

Steps Involved:

1. Proceedings, in the PIL commence and carry on in the same manner, as other cases
2. However, in between the proceedings if the judge feels he may appoint a commissioner, to inspect allegations like pollution being caused, trees being cut, sewer problems, etc
3. After filing of replies, by opposite party, and rejoinder by the petitioner, final hearing takes place, and the judge gives his final decision.

How to file a PIL:

A PIL may be filed like a write petition. However, in the past the SC has treated even letters addressed to the court as PIL. In **People's Democratic Union vs. Union of India**, a letter addressed by the petitioner organization seeking a direction against the respondents for ensuring observance of the provisions of famous labour laws in relation to workmen employed in the construction work of projects connected with the Asian games was entertained as a PIL.
The SC has encouraged the filing of PIL for tackling issues related to environment, human rights etc.

Can a Letter Explaining Certain Facts to the Chief Justice be treated as a PIL?

In early 1990's have there been instances, where judges have treated a post card containing facts, as a Public Interest Litigation For example a letter alleging the illegal limestone quarrying which devastated the fragile environment in the Himalayan foothills around Mussoorie, was treated as a PIL.

Present Scenario:

In the past, many people have tried to misuse the privilege of Pill's and thus now the Court generally requires a detailed narration of facts and complaint, & then decides whether to issue notice and call the opposite party. However, as there is ***no statute*** laying down rules and regulations for a PIL; the Court can treat a letter as a Public Interest Litigation, The letter should bring the true & clear facts, and if the matter is really an urgent one, the court can treat it is a PIL But still it depends upon facts and circumstances, and court has the entire discretion.

Strategies for PIL:

1. The allegations against state and private party should be backed by reliable evidence, for eg in a PIL on malnutrition deaths you need reports indicating it and data of the state regarding child mortality rates from various government surveys. Research based evidence will hold well in a PIL.
2. It will be good to make an NGO working on the issue a party to the petition, if there can be more than one organisation agreeing on an issue it will hold more ground in the court.
3. A good lawyer with an experience in PILS will add advantage for the success of the PIL.

Cehat

Centre for Enquiry into Health and Allied Themes
Research Centre of Anusandhan Trust

CEHAT, in Hindi means "Health". CEHAT, is the research centre of Anusandhan Trust. It is involved in research, action, service and advocacy in health and allied themes. Socially relevant and rigorous academic health research and action at CEHAT is for the well being of the disadvantaged masses, for strengthening people's health movements and for realising right to health care. CEHAT acts as an interface between progressive people's movements and academia.

CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

We are a multi disciplinary team with training and experience in Medicine, Life Sciences, Economics, Social Sciences, Social Work, Journalism and Law. CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, Ethics and Patients' Rights, (3) Women and Health, (4) Investigation and Treatment of Psycho-Social Trauma. An increasing part of this work is being done collaboratively and in partnership with other organisations and institutions.

ICHRL

India Centre for Human Rights & Law

India Centre for Human Rights & Law (ICHRL) was set up in 1997 to defend the rights of the underprivileged, especially the rights of women, children, adivasis, dalits, and ethnic, religious and sexual minorities. ICHRL is a support organization established to provide legal assistance to social movements. In addition to pro bono legal services, ICHRL works to strengthen human rights mechanisms through trainings, investigations and campaigns, to protect civil rights and liberties and safeguard the rights of the poor and marginalized.

ISBN : 81-89042-53-X